Reversing the Obesity Epidemic: *California's Strategies* for Action

Recommendations of the California Obesity Prevention Advisory Group

California Obesity Prevention Initiative

California's Strategies for Action was developed under the leadership of the California Obesity Prevention Initiative, a program of the California Department of Health Services, in collaboration with the University of California, San Francisco, and the University of California, Berkeley. Funding was made possible by the Centers for Disease Control and Prevention, Division of Nutrition and Physical Activity Grant No. U58/CCU119326.

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Suggested Citation: California Obesity Prevention Initiative. *Reversing the Obesity Epidemic: California's Strategies for Action*. Sacramento: California Department of Health Services, 2006.

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In Memory of

Stephen L. Wilkes, who skillfully served as facilitator for the California Obesity Prevention Advisory Group as it developed *Reversing the Obesity Epidemic: California's Strategies for Action*. His perception, warmth, and sense of humor will always be remembered.

COPI also thanks the following individuals involved in writing, editing, and providing extensive input into *California's Strategies for Action:*

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California's Strategies for Action was developed under the leadership of COPI, a program of the California Department of Health Services, supported by the University of California, San Francisco, and funded by the federal Centers for Disease Control and Prevention.

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Introduction

"Because of the increasing rates of obesity, unhealthy eating habits, and physical inactivity, we may see the first generation of children that will be less healthy and have shorter life expectancy than their parents."

RICHARD CARMONA, M.D., SURGEON GENERAL
FORMER U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
MARCH 2004

California is experiencing an unparalleled obesity epidemic that represents a public health challenge of equal magnitude to that of tobacco. Poor diet and physical inactivity are the second leading causes of death and disability, resulting in nearly 30,000 deaths each year in California. The prevalence of overweight in Californians has increased from 38 percent in 1984 to 57 percent in 2003. All gender, age, and race/ethnic groups have shown an increase during the past decade. Californians below the poverty level are disproportionately affected.

With obesity comes associated health risks, including heart disease, type 2 diabetes, high blood pressure, stroke, arthritis-related disabilities, depression, sleep disorders, some cancers, and mental health problems. California's children are suffering unnecessarily from long-term health and emotional impacts of obesity due to experiencing adult-like medical problems at astonishingly younger ages. The economic burden of physical inactivity, overweight, and obesity in adults was $22 billion for California in 2000, and is expected to rise exponentially to $28 billion in 2005 for medical care, workers' compensation and lost productivity.

Given the extent of the problem, California leaders wanted to take action. Key obesity experts, from 50 public and private agencies and organizations at the state and local levels, came together to make recommendations on how to address this significant problem. Together these experts—the California Obesity Prevention Advisory Group—developed *Reversing the Obesity Epidemic: California's Strategies for Action*.

Under the leadership of the California Obesity Prevention Initiative (COPI), a program of the California Department of Health Services (CDHS), partners were brought together from the local, state, and national levels to address the societal, technological, and environmental influences of obesity. In addition, COPI reviewed and drew from other statewide plans to increase coordination, avoid duplication, and identify gaps. The California Obesity Prevention Advisory Group identified six key goals: improving access to physical activity options, particularly family-centered ones; increasing access to healthy foods, particularly in schools and low-income communities; improving access to culturally and linguistically appropriate nutrition and physical activity information to promote life-long skills; developing community-based obesity prevention strategies, particularly within diverse communities; implementing research projects and surveillance systems that identify effective obesity prevention strategies; and improving the ability of health care systems and providers to implement obesity prevention strategies.

California's Strategies for Action is designed to provide options for organizations, agencies, and programs to select obesity prevention and reduction goals and strategies that fit their communities' needs and assets. In addition, state and local level partners are encouraged to work within existing systems, services, efforts, and programs when implementing aspects of *California's Strategies for Action*. For example, a local California Project LEAN (Leaders Encouraging Activity and Nutrition) region; the Women, Infants, and Children Supplemental Nutrition Program; or a school district would build from an existing program, rather than starting anew.

These groups could implement a strategy or strategies from *California's Strategies for Action* that would be most useful in moving their community toward an environment that supports healthy food and physical activity options. Strategies within *California's Strategies for Action* can be tailored to fit the linguistic and cultural needs of diverse communities.

COPI and the California Obesity Prevention Advisory Group encourage communities and state-level programs and organizations across California to peruse *California's Strategies for Action*, identify goals and strategies that meet their needs and strengthen their assets, and begin to move to action. These are the first steps toward a healthier California.

Building a Foundation for Obesity and Chronic Disease Prevention in California

In October 2000, California was one of six states funded by a three-year grant from the Centers for Disease Control and Prevention (CDC) to combat the growing obesity epidemic. Organized within CDHS, Epidemiology and Health Promotion Section, with support from the University of California, San Francisco, COPI seeks to:

- Build an infrastructure for obesity and chronic disease prevention in California.
- Create a state nutrition and physical activity strategy to prevent obesity and chronic disease.
- Develop and implement a pilot intervention for youth.
- Identify and improve relevant data and surveillance sources.
- Provide training and technical assistance to collaborative partners.

COPI works with many collaborative partners who have shaped the development of the initiative through two planning groups—the internal CDHS COPI Planning Group and the external California Obesity Prevention Advisory Group. The internal CDHS Planning Group is comprised of programs within CDHS, such as Cancer Prevention and Nutrition Section; Office of Clinical Preventive Medicine; California Project LEAN; California Center for Physical Activity (formerly the Physical Activity and Health Initiative); Maternal and Child Health (MCH) Branch; Children's Medical Services (CMS) Branch; Medi-Cal Managed Care Division; Women, Infants, and Children (WIC) Branch; California Diabetes Prevention and Control Program; California Heart Disease and Stroke Prevention Program; Cancer Control Branch; and School Health Connections. This group serves as a forum to improve collaboration between CDHS programs that address nutrition, physical activity, and obesity issues. The larger California Obesity Prevention Advisory Group is comprised of over 90 people, primarily external partners, who are experts in the field of obesity prevention, nutrition, and physical activity issues.

Its members include representatives from local public health departments, public health advocacy groups, transportation planning groups, the California Department of Education (CDE), the faith community, city government, the American Academy of Pediatrics, Cooperative Extension, parks and recreation, universities, volunteer organizations, and a number of other groups and organizations. (See Acknowledgments.)

In addition, COPI formed two workgroups—the Evaluation and Surveillance Workgroup and the Health Systems Workgroup. These two groups led the effort to improve the ability of the state surveillance and health care systems to respond to the obesity epidemic. The Evaluation and Surveillance Workgroup's original charge was to review current surveillance systems within California, evaluate their ability to determine the prevalence of obesity and related behaviors, and make recommendations for improvement. This workgroup has members from inside and outside of State Government. In addition to CDHS programs, members include CDE; University of California, Berkeley; University of California, Los Angeles; and Los Angeles County Health Department. The Health Systems Workgroup is comprised of members from the state's Office of Clinical Preventive Medicine, Medi-Cal Managed Care, other health plans, as well as other academic institutions. The Health Systems Workgroup was tasked with exploring current health plan practices related to obesity prevention and treatment and making recommendations for improvement.

Development of California's Obesity Prevention Strategy

To complete *California's Strategies for Action*, COPI drew from the expertise of its planning groups and workgroups. COPI conducted key informant interviews with California's nutrition and physical activity leaders and facilitated meetings to collect information on research, opportunities, barriers, and recommended strategies related to obesity prevention. In June 2001, COPI convened approximately 90 key California health and community leaders for a two-day meeting. As a recommendation from that meeting, COPI conducted ten community meetings with African Americans and Latinos, two of California's ethnic groups most seriously affected by the obesity epidemic. The meetings elicited the opinions of both community members and leaders on how best to address the increasing obesity concerns and disparities in these populations.

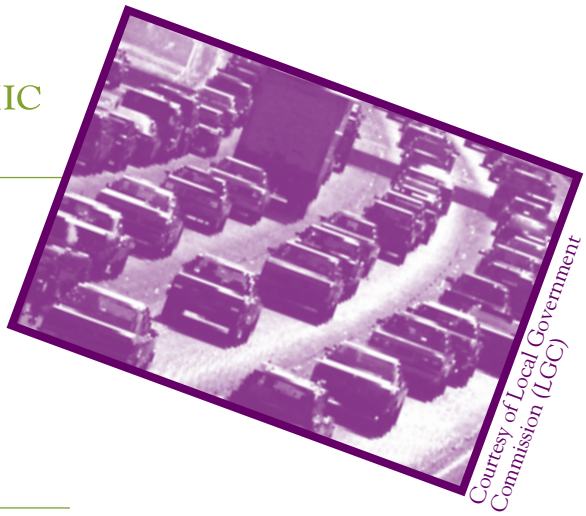
As the data was analyzed and components of the strategy were developed and recorded, email alerts and face-to-face meetings provided partners with opportunities to provide additional feedback.

California's Strategies for Action incorporates data and research from several documents produced by COPI. *Obesity Prevention in the African-American and Latino Communities of California* provides a summary of findings from the ethnic specific community meetings. (See Appendix II.) *Pediatric Overweight: A Review of the Literature* was researched and compiled by the University of California, Berkeley, Center for Weight and Health, to inform COPI of youth-related overweight issues. The Obesity Prevention for Health Care Systems: Literature Review was developed by the COPI Health Systems Workgroup. A summary of survey responses from California's Medi-Cal managed care health plans detailed services and needs related to obesity prevention and treatment. Lastly, the COPI Evaluation and Surveillance Workgroup completed a summary of obesity-related data and surveillance systems in California. (See Appendix IV.)

California's Obesity Epidemic

"Overweight and obesity are among the most pressing new health challenges we face today."

TOMMY THOMPSON
FORMER U.S. HEALTH AND
HUMAN SERVICES SECRETARY



Courtesy of Local Government Commission (LGC)

Almost two-thirds of California adults are overweight or obese, and about one in three children and one in four teens is at risk or already overweight (California Behavioral Risk Factor Surveillance Survey, 2004; CalCHEEPS, 2005; CalTEENS 2005).

Available data indicate that overweight and obesity affect virtually all age, income, educational, and ethnic groups. Especially high rates are found among California's African-American, Latino, and American Indian/Alaska Native adult populations.

Such high rates may contribute to other health issues experienced by these groups, such as type 2 diabetes.

California youth are also impacted by the obesity epidemic. Data from the 2004 CDE FITNESSGRAM reveals the following about children in grades five, seven, and nine:

- Only 25 percent of the students tested in grade five, 29 percent in grade seven, and 26 percent in grade nine met the minimum fitness standards.

Diabetes by Race/Ethnicity in California

RACE /ETHNICITY	DIABETES PREVALENCE
African American	9.3%
Latino/Hispanic	7.5%
American Indian/Alaska Native	9.9%
White	5.6%

Source: California Health Interview Survey, 2003

"The health of the nation's children has been set back 30 years by a rising tide of obesity, to a point that it could be considered a modern day epidemic."

CHILD WELL-BEING INDEX
DUKE UNIVERSITY
MARCH 2004

Body Mass Index by Race/Ethnicity in California

RACE/ETHNICITY	BODY MASS INDEX OVER 25.0
African American	70.4%
Latino/Hispanic	69.6%
Other	40.4%
White	53.0%

Source: California Behavioral Risk Factor Surveillance Survey, 2004

Almost 1.4 million students participated in the 2004 FITNESSGRAM, which assessed six major fitness areas, including aerobic capacity, body composition, abdominal strength and endurance, trunk strength and flexibility, upper body strength and endurance, and overall flexibility.

According to a 2005 study, *An Epidemic: Overweight and Unfit Children in California Assembly Districts*, produced by the California Center for Public Health Advocacy:

- 28.1 percent of the state's students are overweight.
- Urban Los Angeles County and the rural Central Valley have the highest rates of overweight.
- African-American, American Indian, and Latino youth face higher rates of overweight and poor fitness than White and Asian youth.

National and state surveys indicate that rates of overweight and obesity began to rise in the late 1980s, accelerated in the 1990s, and as yet in this decade show no signs of slowing. Of the nation's ten Leading Health Indicators for *Healthy People 2010*, only overweight and obesity are moving strongly in the wrong direction. (See Appendix III.)

A study by CDC focused on state-level estimates of direct costs, including total Medicare and Medicaid obesity attributable medical expenditures. California's cost figures were approximately $7.7 billion. (Obesity Research; Finkelstein, Fiebelkorn, and Wang, 2004.)

"The health of our children, ourselves and our environment cannot continue to tolerate poorly-planned sprawling developments that promote an auto-oriented lifestyle. We need to bring back compact, traditional neighborhoods that are within walking or biking distance of open space, schools, stores, offices, recreational facilities and public transit."

JUDY CORBETT
EXECUTIVE DIRECTOR
LOCAL GOVERNMENT COMMISSION

A Complex Problem Calls for Multi-Faceted Solutions

Proposed Causes

The worldwide spread of obesity has been attributed to complex, powerful societal forces that encourage eating too many high calorie foods, getting too little physical activity, and acquiring too much body weight over time. The pressure to eat more food has become increasingly pervasive. Large portions of high calorie foods with little nutritional value are mass produced, heavily advertised, and made widely available throughout the day, while the opposite is generally true for healthier foods like fruits and vegetables. Increased marketing of high calorie, low nutrient foods to children; lack of access to healthier foods in workplaces, schools, and many lower-income communities; and food insecurity—in addition to a host of other barriers—make it difficult for individuals to maintain a healthy diet.

Technology has decreased the extent of physical activity in most workplaces, in daily living, for transportation, and during leisure. Renewed emphasis on academic achievement in the educational system has reduced the time and space available for active play as well as for structured physical education. Long work days and single-parent households limit time for physical activity. Safety concerns, poor community design, and urban sprawl discourage walking, bicycling, and recreation in many neighborhoods. Time spent watching television plays an important role in obesity. Children who watch four hours or more of television per day weigh significantly more than children watching fewer than two hours per day.

Even factors occurring very early or for brief periods in life can contribute to obesity later in life. These include high birth weight from uncontrolled diabetes, low birth weight, and lack of breastfeeding.

Possible Solutions

Because health behaviors are very complex and influenced by many factors, multi-faceted solutions are needed. Research and everyday practice demonstrate that knowledge alone does not lead to behavior change. The key to preventing or reducing overweight and obesity is to think beyond the usual ideas of classes, health facts, and public service announcements. Multi-level solutions that change the political, social, and physical environments where people live, work, and play are essential in order to make significant progress.

CDC recommends five areas of intervention for obesity and chronic disease prevention.

- **Reduction of television viewing by children**

National crosscutting surveys have shown a positive association between the number of hours children watch television and prevalence of overweight. However, the mechanism for the relationship between television time and overweight has not been clearly determined. Mechanisms may include increased caloric intake while watching television, influence of food advertising on food selection, and reduction of metabolic rate.

- **Increased physical activity**

Regular physical activity substantially reduces the risk of obesity and chronic disease. Strategies are encouraged that address environmental and policy approaches to promoting and supporting physical activity, rather than strategies that only promote individual behavior change.

- **Increased breastfeeding**

There is a growing body of evidence that suggests that breastfeeding offers protection against childhood overweight. The mechanism by which this occurs is not clear. Strategies are encouraged that address environmental and policy approaches to promoting and supporting breastfeeding, in addition to strategies that promote individual education.

- **Increased fruit and vegetable consumption**

Fruits and vegetables provide vital nutrients critical to good health. Increased consumption of fruits and vegetables has been clearly associated with decreased risk of cancer, cardiovascular disease, and high blood pressure. However, effective strategies that result in increased consumption are not as clear. Few previously implemented strategies have been vigorously evaluated, particularly for actual behavior change. Research into 5 A Day strategies that achieve increased consumption is needed.

- **Energy balance**

Weight gain occurs when caloric intake exceeds caloric expenditure. CDC notes that it is difficult to provide recommendations for dietary strategies because of inadequate scientific research. However, CDC does encourage research into strategies that address dietary fat, dietary fiber, macro-nutrients, satiety, energy density, sweetened beverages, fast foods and restaurant use, dietary patterns, portion size, family/parental involvement, and calcium/dairy consumption.

CDC also recommends a social-ecological approach to obesity and chronic disease prevention that seeks change at multiple levels of society. One tool that can help accomplish this comprehensive strategy that has been used extensively in California is the Spectrum of Prevention from the Prevention Institute. (See Appendix I, Reference 17.) The Spectrum of Prevention offers a framework for thinking comprehensively about obesity and chronic disease prevention.

The Spectrum of Prevention includes six levels at which action must occur in order for health behaviors to be affected:

- Influencing policy and legislation (Level Six)
- Changing organizational practices (Level Five)
- Fostering coalitions and networks (Level Four)
- Educating providers (Level Three)
- Promoting community education (Level Two)
- Strengthening individual knowledge and skills (Level One)

California Takes Action

Many organizations within California have already have begun to individually and collectively address the state's obesity problem. The 2001, 2003, and 2005, California Childhood Obesity Conferences were highly attended (800, 1,200, and 1,400, respectively) by professionals from organizations addressing obesity prevention and control. Many of the organizations represented at these conferences used a wide variety of strategies that address all levels of the Spectrum of Prevention in an effort to increase healthy eating and physical activity in California. A short listing of California examples, organized by the Spectrum of Prevention levels, includes:

- **Influencing policy and legislation (LEVEL SIX)**

The Strategic Alliance for Healthy Food and Physical Activity Environments (The Alliance) strives to reframe the debate on nutrition and physical activity from a matter of individual choice and lifestyle to an issue of environmental, corporate, and government responsibility. The Alliance, comprised of organizations and individuals committed to the same vision, serves as an independent voice that is separate from but able to influence government and industry. Working with a broad-based coalition, the Alliance has worked to improve the availability of nutritious foods in public schools through the passage of Senate Bill (SB) 19, in 2001 (Escutia) and SB 12 and SB 965 (Escutia) in 2005. SB 19 established School Food and Beverage Standards for California's elementary schools; SB 12 and SB 965 strengthened these standards and expanded them to include middle and high schools. These bills, the first of their kind in the nation, established nutrient standards for food and beverages sold in California schools K-12.

California Food Policy Advocates (CFPA) works to increase the number of students offered breakfast at school. Based on research demonstrating that children who eat school breakfast perform better on standardized tests and are less disruptive in class, CFPA is taking steps to ensure that every student starts the day with breakfast.

- **Changing organizational practices (LEVEL FIVE)**

California Project LEAN, a program of CDHS and the Public Health Institute (PHI), has formed a partnership with the California School Boards Association to assist school boards in creating and implementing healthy eating and physical activity policies. As a "local control" state, California looks to its approximately 1,000 school districts and their boards to create policies that support healthy environments for students and

staff. Through a policy manual, publications, and local trainings, Project LEAN and the California School Boards Association are changing the way school districts support and promote healthy eating and physical activity.

- **Fostering coalitions and networks (LEVEL FOUR)**

The Center for Weight and Health at the University of California (UC), Berkeley, facilitates interactions among researchers, policy makers, and community-based providers who are concerned about weight, health, and food security. One of the Center's projects, "Children and Weight: What Communities Can Do," provides low-income schools and communities with the resources to create healthy environments. Through its corresponding tool kit, the Center facilitates community action by empowering and mobilizing communities to create opportunities for young people to eat healthy and be physically active.

- **Educating providers (LEVEL THREE)**

The California Health Interview Survey (CHIS) provides health planners, policy makers, counties, and communities a detailed picture of the health issues facing California's diverse populations. The 2001 data is based on 73,821 interviews with adolescents and adults. CHIS collects information on a variety of health conditions, including overweight and obesity and related diseases, such as cancer, heart disease, and diabetes. The survey also provides local-level estimates for most counties. CHIS is a collaborative project of the University of California, Los Angeles, Center for Health Policy Research, CDHS, and PHI. CHIS is the largest state health survey in the United States.

- **Promoting community education (LEVEL TWO)**

California's Walk to School Headquarters, operated by the California Center for Physical Activity (formerly the Physical Activity and Health Initiative) of CDHS, provides tools and tips for parents, teachers, and local leaders to organize local walk to school events and programs. Annual walk events are both educational and fun and give students and adults the opportunity to learn about the benefits of walking to school. A walkability checklist, downloadable at www.cawalktoschool.com, helps school staff, parents, and students identify and then address any barriers to walking to school for students.

- **Strengthen individual knowledge and skills (LEVEL ONE)**

The California Nutrition Network creates innovative partnerships to encourage low-income Californians to adopt healthy eating and physical activity patterns as part of a healthy lifestyle. The Network utilizes a wide variety of strategies to encourage knowledge and skill development. Media strategies include the purchase of television and radio airtime, the placement of outdoor advertisements, customized point-of-sale materials, and in-store recipe booklets. The Network also funds nearly 300 local projects to serve as "ambassadors" in delivering the 5 A Day, physical activity, and food security messages through various intervention levels.

Additional innovative California programs can be found at www.cnr.berkeley.edu/cwh. Although there seems to be an overwhelming amount of activity in California on obesity and chronic disease prevention, this website, hosted by the UC Berkeley Center for Weight and Health, offers a manageable mechanism for organizations to post and share successful programs related to obesity prevention and treatment.

California's Goals to Reduce the Obesity Epidemic

Based on research, CDC recommendations, input and guidance from the internal and external COPI planning and advisory groups, workgroups, and the ethnic-specific community meetings, California identified the following goals:

- Increase access to physical activity options, including family-centered ones, to increase rates of physical activity and decrease rates of physical inactivity.
- Improve access to healthy foods, particularly in schools and low-income communities, to increase consumption of fruits and vegetables; decrease consumption of high calorie, low nutrient foods; and decrease food insecurity and hunger.
- Improve access to culturally and linguistically appropriate nutrition and physical activity information to promote life-long skills.
- Develop community-based obesity prevention strategies, particularly within diverse communities.
- Implement research projects and surveillance systems that identify effective obesity prevention strategies.
- Improve the ability of health care systems and providers to implement obesity-related primary prevention, early intervention and treatment strategies, particularly in a culturally and linguistically appropriate manner.

Promising Strategies

COPI's Statewide Planning Group recommended promising strategies within each of the six goals. The strategies are organized under five settings where people work, live, and play: families and communities, schools, health care, media and communications, and worksites. A notation has been made next to each strategy as to its Spectrum of Prevention level. Strategies specifically identified through the African-American and Latino community meetings are denoted with an asterisk (*).

Goal #1:

Increase access to physical activity options, including family-centered ones, to increase rates of physical activity and decrease rates of physical inactivity.

Families and Communities

LEVEL SIX

- Encourage smart growth and zoning in communities as a mechanism for encouraging nonmotorized transportation, such as walking and biking.
  - Limit size of shopping centers.
  - Redesign zoning to combine shops, homes, schools, parks, and business.
  - Decrease gated communities and cul-de-sacs.
  - Limit development of agricultural land.
- Place limits on automobile use as a mechanism for encouraging nonmotorized transportation, such as walking and biking.
  - Create car free places and times to encourage pedestrian usage.
  - Limit parking to increase public transit usage and increase green space, which encourages incidental physical activity
- Increase access and quality of public transportation to reinforce the use of nonmotorized modes of transportation, such as walking and biking.*
- Make buses and trains free and accessible.
  - Encourage inter-modality.
- Provide tax incentives/disincentives for transportation choices as a mechanism for encouraging nonmotorized transportation, such as walking and biking.
- Use tax monies to fund physical activity programs.

LEVEL FIVE

- Create more usable walk/bike paths.
  - Mandate "facility development," including bike parking.
  - Promote friendly, safe, attractive community design that supports physical activity.

LEVEL FOUR

- Create partnerships between statewide urban planning agencies, law enforcement agencies, and community leaders to create and promote "violence-free," family physical activity zones within parks and neighborhoods.*
- Increase the safety of communities.*

"The built environment presents both opportunities for and barriers to participation in physical activity, thereby influencing whether or not we exercise."

RICHARD JACKSON, M.D., M.P.H.
FORMER STATE PUBLIC HEALTH OFFICER
CALIFORNIA DEPARTMENT OF
HEALTH SERVICES

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LEVEL TWO

- Develop community-based, parent-run babysitting cooperatives that would enable parents to exercise regularly.*
- Encourage community gardens.
- Promote family/neighborhood physical activity like biking and walking.*
- Work with beauty salons to sponsor classes that teach African-American women and girls how to maintain their hair for exercise.*

Schools

LEVEL SIX

- Mandate daily physical education in Grades K-12.
- Subsidize physical education and physical activity programs at schools to increase participation by the children and the community at large.

LEVEL FIVE

- Extend the school day to accommodate more time for physical education.

LEVEL THREE

- Increase the quantity and quality of certified physical education teachers.

LEVEL ONE

- Create fun and physically active after-school programs.

Worksites

LEVEL SIX

- Provide tax benefits for employers who provide employee wellness programs.

LEVEL FIVE

- Encourage worksites to provide time, exercise equipment, and showers for employees who want to exercise during the workday.

LEVEL FOUR

- Facilitate dialog between unions, employers, and employees to increase access to physical activity at work.

Goal #2:

Improve access to healthy foods, particularly in schools and low-income communities, to increase consumption of fruits and vegetables, decrease consumption of high calorie, low-nutrient foods, and decrease food insecurity and hunger.

Families and Communities

LEVEL SIX

- Require all restaurants to provide nutrient labeling for all their foods.
- Utilize local zoning regulations to limit fast food vendors and eating establishments.
- Use tax monies to fund healthy eating programs.
- Subsidize the development, purchase, and sale of healthy foods.

LEVEL FIVE

- Advocate for appropriate portion sizes at restaurants, fast food outlets, concessions, and other food outlets.

LEVEL FOUR

- Develop partnerships with the food industry to offer healthier choices in restaurants and food source outlets.*
- Assist schools, after school programs, community-based organizations, and faith-based organizations to identify ways to provide healthier foods.

LEVEL TWO

- Help low-income communities attract major grocery store chains that will build in their areas.*

LEVEL ONE

- Develop and utilize an advocacy guide to train community agencies and parent advocacy groups to work with schools to create healthy nutrition and physical activity policies.*

> ***"Schools should be a nutritional safe-haven for our children, not just another place where people make money selling them junk food and soda. Children learn not only by what we tell them, but also by what we sell them."***
>
> **HAROLD GOLDSTEIN, DR.PH**
> EXECUTIVE DIRECTOR
> CALIFORNIA CENTER FOR PUBLIC HEALTH ADVOCACY

Schools

LEVEL FIVE

- Implement healthy school food policies.*
- Encourage a garden in every school.
- Increase participation in CDE child care feeding programs, school nutrition, and other food assistance programs.

Health Care

LEVEL FIVE

- Expand WIC farmers' market program, improve the WIC food package to include fruits and vegetables, and improve the quality of nutrition, physical activity, and breastfeeding education in WIC programs.

Worksites

LEVEL SIX

- Provide tax benefits for employers who provide employee wellness programs.

LEVEL FIVE

- Assist worksites to promote breastfeeding through the provision of lactation rooms, as now required by law.

LEVEL FOUR

- Facilitate dialog between unions, employers, and employees on how to increase access to healthy foods at work.

Goal #3:

Improve access to culturally and linguistically appropriate nutrition and physical activity information to promote life-long skills.

Families and Communities

LEVEL SIX

- Require all restaurants to provide nutrient labeling for all foods sold.

LEVEL FOUR

- Partner with faith-based communities to conduct health promotion programs.*

LEVEL THREE

- Support peer-led education programs that reach community members with nutrition and physical activity information and skills.*

LEVEL ONE

- Develop resources that teach people how to make traditional cultural recipes in a healthier manner.*

Health Care

LEVEL ONE

- Create and maintain advisory bodies to COPI with health providers, educators, community leaders, and community members from diverse communities who can advise COPI on future activities.*

Media and Communications

LEVEL FIVE

- Increase the consistency and reliability of the dietary guidelines.

LEVEL THREE

- Develop a clearinghouse of nutrition and physical activity resources and information that can be easily accessed by community leaders, particularly those working with diverse communities.*

LEVEL TWO

- Provide advertising dollars to promote healthy eating and physical activity.
- Develop a statewide media campaign that focuses on nutrition and physical activity issues relevant to different race/ethnic groups.*

LEVEL ONE

- Develop educational materials that address the needs of different groups such as women, men, parents, teens, and race/ethnic groups.*

Goal #4:

Develop community-based obesity prevention strategies, particularly within diverse communities.

Families and Communities

LEVEL SIX

- Provide state funds for community-based obesity prevention activities/programs.*

LEVEL FIVE

- Increase funding for farmers' market nutrition programs. Develop church-sponsored farmers' markets.*
- Increase access to healthy foods.

LEVEL FOUR

- Host local discussions/forums, particularly in diverse communities, to create dialogue about obesity prevention.*
- Encourage partnerships between local restaurants, stores, and community leaders to find ways to increase the number of healthy food choices in restaurants and food source outlets.
- Allocate substantial, long-term program funds to community-based and faith-based organizations, particularly those serving diverse communities, to develop and conduct obesity prevention activities.*

LEVEL THREE

- Put prompts for healthy behaviors in the community such as signs that promote taking the stairs, using parks, and choosing healthy foods.

LEVEL ONE

- Encourage community gardens.
- Develop low-cost, healthy cooking classes.

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Schools

LEVEL SIX

- Adopt standards for healthy foods and beverages sold and served at schools.

LEVEL FIVE

- Create fun and physically active after-school programs.

LEVEL ONE

- Provide low-cost, physically active after-school programs.

Health Care

LEVEL FOUR

- Increase collaboration among programs within CDHS, particularly those that focus on disease prevention, tobacco control, and services to low-income Californians.
- Create coordinated and proactive state leadership, including at the gubernatorial level, on the obesity issue.*

Media and Communications

LEVEL FOUR

- Utilize media advocacy to promote public policy changes.
- Develop a media campaign to promote positive choices.

LEVEL ONE

- Develop resources that promote the reduction of television viewing.

Worksites

LEVEL FIVE

- Improve workplace facilities such as showers, activity facilities, food preparation and storage facilities, and lactation rooms.

Goal #5:

Implement research projects and surveillance systems to determine effective obesity prevention strategies.

Health Care

LEVEL SIX

- Develop a long-term, stable source of funds and resources to support statewide monitoring systems.

LEVEL FIVE

- Explore the possibility/feasibility of standardizing questions and data collection methods between national and state monitoring systems and among several state monitoring systems.

LEVEL FOUR

- Continue to convene COPI's Evaluation and Surveillance Workgroup to make recommendations to strengthen/develop monitoring systems to track overweight and obesity prevalence, as well as physical activity and nutrition behaviors.
- Continue to convene COPI's Evaluation and Surveillance Workgroup to assess current data sources.

LEVEL THREE

- Develop and disseminate tools and training forums on appropriate utilization of CDC Growth Charts.

LEVEL ONE

- Encourage research that examines the ability of individually adapted health behavior programs issued by a medical provider to increase physical activity behavior.
- Encourage research into the effectiveness of various weight management strategies utilized within a variety of health care settings.
- Encourage research that examines how mental health is linked with overweight and obesity.*

Media and Communications

LEVEL THREE

- Identify and disseminate information regarding existing local and national programs that have been successful in addressing obesity prevention, particularly within diverse communities.*

Goal #6

Improve the ability of health care systems and providers to implement obesity primary prevention, early intervention, and treatment strategies, particularly in a culturally and linguistically appropriate manner.

Families and Communities

LEVEL THREE

- Develop or identify paradigms for working with nontraditional family structures (for example: grandparents, single parents, extended families, etc.) and disseminate this information to obesity prevention providers.*

Health Care

LEVEL SIX

- Institute provider reimbursement for obesity prevention services.
- Increase access to health care and hospitals for obesity prevention and control services.

LEVEL FIVE

- Provide health behavior incentives.
- Increase the number of culturally sensitive and/or bilingual staff and providers.*

LEVEL FOUR

- Seek funding to support best practices and Quality Improvement Profile development among Medi-Cal managed care plans.
- Encourage health plans to develop a team approach to weight management that includes physicians, registered dietitians, health educators, and other support staff.

LEVEL THREE

- Institute provider education and training on nutrition, physical activity, and obesity prevention.
- Create a provider toolkit that contains the latest research and resources related to obesity prevention and weight management.
- Collect current research on effective pharmacological and bariatric surgery treatment regimens and develop summary recommendations for providers.
- Develop a cultural competency tool for medical providers to assist them in talking with patients from different cultures about obesity, nutrition, and physical activity.*

LEVEL ONE

- Increase the number of health promotion programs and obesity prevention efforts, particularly related to breast feeding promotion, in the health care setting.
- Increase the ability of providers to advise their patients on healthy eating and physical activity as a means to maintaining a healthy weight.
- Utilize the Transtheoretical Model as a guide to assessing patients' readiness to make nutritional and physical activity changes.

Issues to Consider in Moving to Action

California's leaders recommended many diverse strategies as a means of achieving these goals. Some can be accomplished with current resources and partners; others require new financial resources and new partners. Participants in COPI's planning sessions suggested criteria for building successful obesity prevention strategies. Each of these items should be considered as organizations move forward on the goals and strategies:

1. **Evidence-based**—Has research/evaluation shown that the strategies are effective?
2. **Coordinated and collaborative**—Have actual and potential partners been identified and consulted?
3. **Funding available or attainable**—Are adequate funds available for implementation?
4. **Sustainable**—Will the project or its outcomes remain after funding ceases?
5. **Measurable outcomes**—Will measurable change(s) result from the intervention?
6. **Level of support and/or opposition**—Is the level of support for the intervention greater than the level of opposition?
7. **Early successes guaranteed**—Will the intervention change people's lives quickly?
8. **Community involvement in the design and implementation**—Have audience members and their community been put at the center of the design and implementation of the intervention?

COPI's Statewide Planning participants also suggested the following cautions when designing obesity prevention strategies:

1. **Diets do not work.** Research shows that most people have very little long-term success in losing weight.
2. **Focus on behavior change.** Constantly evaluate whether the program is effective at helping people to change their behavior.
3. **Lead by example. Serve as a model.** For example, serve healthy foods and provide physical activity breaks to participants. Provide healthy options in cafeterias and vending machines.
4. **Emphasize healthy lifestyle goals, not necessarily weight goals.** Although our goal is to enable more Californians to maintain a healthy weight, we must realize that this may not be possible for all people. Promoting healthy lifestyle choices and healthy environments for all people is more realistic.
5. **Incorporate cultural perspectives into obesity prevention programs.** Cultural aspects are often at the core of how people perceive and act on healthy eating, physical activity, and weight issues. Without taking these perspectives into account, programs risk being ineffective.

California Obesity Prevention Initiative's Next Steps

During the next five years, COPI will move to action by facilitating and/or implementing selected strategies from *California's Strategies for Action*. The following objectives will be addressed:

- **Maintaining a state infrastructure to prevent obesity and related chronic diseases through healthy eating, increased physical activity and supportive community design.**
  - Provide technical support for the Administration's Action Plan and CDHS' department-wide Obesity Prevention Initiative.
  - Serve as a leader for California on the issue of obesity prevention, actively working with state and local-level partners.
  - Build a local-level infrastructure by funding communities to enhance their food and physical activity environments, systems, and policies.
- **Increasing the number of internal and external partners participating in obesity prevention efforts.**
  - Work collaboratively with state and local programs and organizations in a coordinating role to support nutrition, physical activity, and obesity prevention related activities.
  - Maintain and expand communication with other California state departments, commissions, and boards. (e.g., CDE, California State Parks and California Children and Families Commission)
  - Work jointly with California's Strategic Alliance, a statewide coalition that promotes environmental approaches to healthy eating and physical activity.
- **Providing technical assistance and training (TAT) to internal and external partners.**
  - Maintain and expand TAT through a variety of approaches, including the COPI website, presentations, and representing CDHS on task forces and advisory groups.
  - Provide TAT on reducing screen time in youth, using COPI's *Do More, Watch Less!* tool.
  - Serve as a co-facilitator and planning team member for the 2007 California Childhood Obesity Conference, the largest of its kind in the nation, together with other CDHS programs, CDE, and UC Berkeley.

- **Increasing access to physical activity options, particularly family-centered ones.**
  - Promote expanded community involvement in city and county planning efforts to improve access to physical activity.
  - Increase visibility/promotion of local-level infrastructure changes that support walk-and bike-friendly communities.
  - Increase opportunities for physical activity at the school site, throughout the day and on the weekends.
- **Increasing access to healthy foods, particularly in schools and low-income communities.**
  - Provide support for eliminating unhealthy food and beverages in California schools by:
    - Supporting the implementation of the ban on soda on high school campuses; and
    - Supporting implementation of nutrition standards for food and beverages sold in schools during school hours.
  - Support improved access to and participation in school breakfast programs.
  - Advocate for ongoing funding for local-level coalitions to drive changes in environments, systems, and policies so that healthy choices become natural and easy choices.
- **Increasing access to culturally and linguistically appropriate nutrition and physical activity information to promote life-long skills.**
  - Support peer-led education programs (e.g., use of promotoras) that reach community members with nutrition and physical activity information and skills.
- **Supporting the development of community-based obesity prevention strategies, particularly within diverse communities.**
  - Advocate for ongoing funding for local-level, community-based grants to drive changes in environments, systems, and policies so that healthy choices become natural and easy choices.
- **Supporting research and surveillance that determine effective obesity prevention strategies.**
  - Assist the CDHS tracking and evaluation team in strengthening and expanding the monitoring systems that assess the upstream causes of obesity, the prevalence of trend data, and the impact of interventions and policy decisions.
- **Increasing the ability of the health care system to promote obesity prevention, particularly in a culturally and linguistically appropriate manner.**
  - Through the Health Systems Workgroup, collaborate with providers and health plans to design system changes that will improve delivery of health care services to prevent pediatric overweight.
  - Support increased access to obesity prevention and weight management services in public health plans, specifically Medi-Cal and Healthy Families.

Creating a Joint Effort in California

While COPI serves as a catalyst for obesity prevention work, it cannot solve California's epidemic alone. Despite considerable efforts to improve food and physical activity environments within the state, the majority of California residents continue to struggle with physical inactivity and unhealthy eating habits. California faces a tremendous task in reversing the obesity epidemic.

To stem the tide of overweight and obesity, organizations across California need to work together to implement multi-level solutions that change the political, social, and physical environments where people live, work, and play. In doing so, communities throughout California can create environments where healthy food and active living are the norm.

"Many people believe that dealing with overweight and obesity is a personal responsibility. To some degree they are right, but it is also a community responsibility. When there are no safe, accessible places for children to play or adults to walk, jog, or ride a bike, that is a community responsibility. When school lunchrooms or office cafeterias do not provide healthy and appealing food choices, that is a community responsibility. When new or expectant mothers are not educated about the benefits of breastfeeding, that is a community responsibility. When we do not require daily physical education in our schools, that is also a community responsibility. There is much that we can and should do together."

DAVID SATCHER, M.D., Ph.D.
FORMER SURGEON GENERAL

Appendix I

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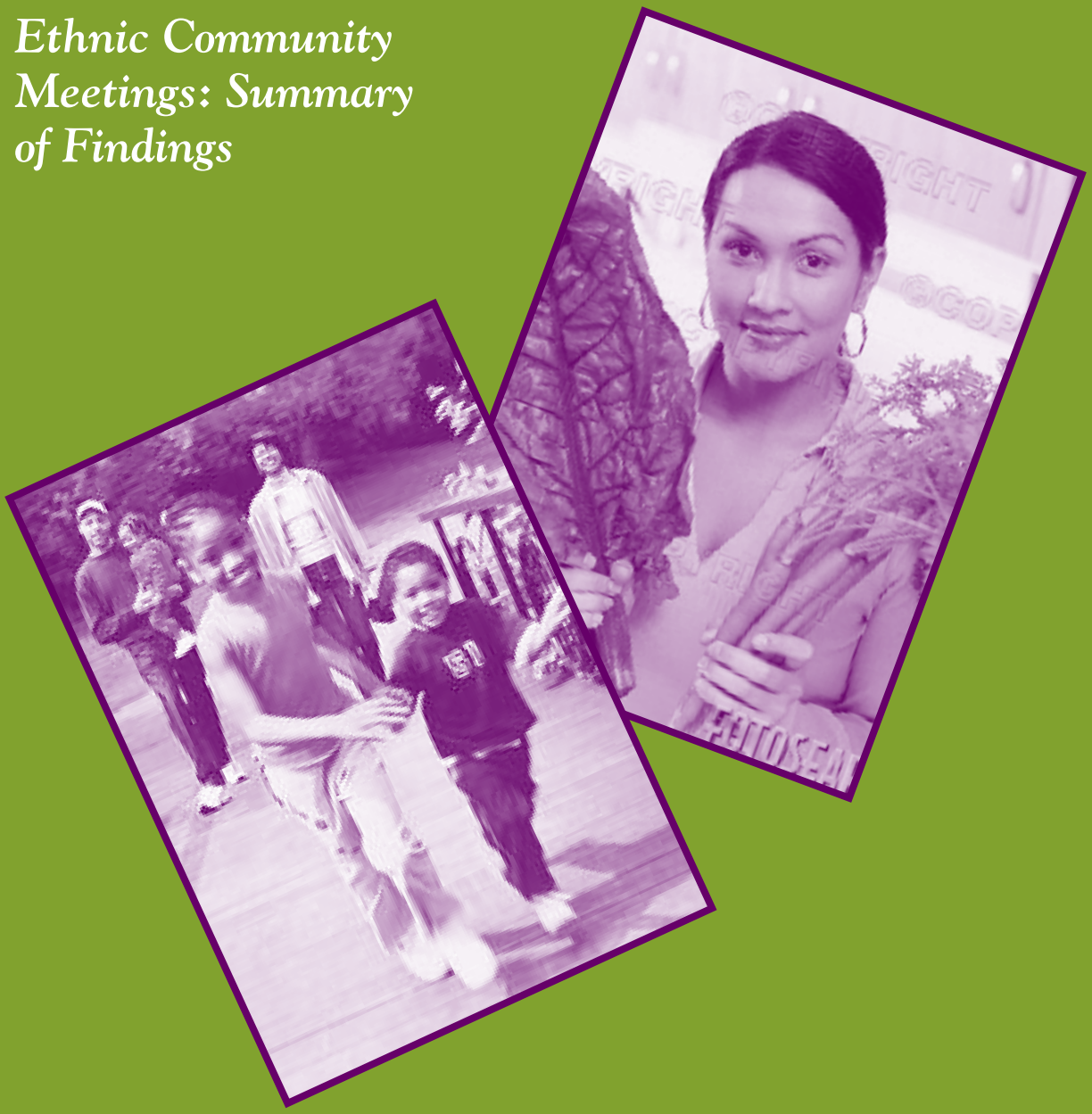
Appendix II

Obesity Prevention in the African-American & Latino Communities *of California*

Ethnic Community Meetings: Summary of Findings



California Department of Health Services, California Obesity Prevention Initiative Program

California's Strategies for Action was developed under the leadership of the California Obesity Prevention Initiative, a program of the California Department of Health Services, in collaboration with the University of California, San Francisco, and the University of California, Berkeley. Funding was made possible by the Centers for Disease Control and Prevention, Division of Nutrition and Physical Activity Grant No. U58/CCU119326.

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Suggested Citation: California Obesity Prevention Initiative. *Obesity Prevention in the African-American and Latino Communities of California*. Sacramento: California Department of Health Services, 2006.

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Acknowledgments

California Obesity Prevention Initiative (COPI) would like to thank the following people for their time, commitment, and feedback at the African-American and Latino community meetings. Their thoughts and ideas are appreciated and will be invaluable to the health and well being of many Californians.

African-American Community Meetings

SACRAMENTO PROFESSIONAL MEETING:

MaeRetha Franklin
California Department of Health Services Office of Women's Health

Reverend Joe Goree

Kathryn Hall
Center for Community Health and Well Being

Betty Haynes
Black Infant Health Program

Yvonne Nicholson
University of California Cooperative Extension

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California Department of Health Services Black Infant Health Program

Jacquelyn Ward
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Great Beginnings for Black Babies

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Gwendolyn Flynn
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Janette Robinson Flint
Black Women for Wellness

Sylvia Drew Ivie
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Yolanda Lean
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Jeira Brito
Norma Carter
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Robert L. Holeman
Sibyl Howard
E. Valeria Norwood
Dr. Bernice Reams
Phyllis Stephenson
Gwen Uman
Dorris Woods

FRESNO COMMUNITY MEETING:

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Diane Foster
Dr. Nicole Guppy
Keith Kelley
Mary McCoy
Reverend Paul McCoy
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Latino Community Meetings

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Executive Summary

Obesity among African Americans and Latinos in California is pervasive and has far-reaching and potentially devastating implications for the health and wellness of these communities. In California, 64 percent of Latinos and 67 percent of African Americans are overweight or obese, as opposed to 32 percent of Asians and 54 percent of Caucasians (California Health Interview Survey, 2001). Many illnesses associated with morbidity and mortality in both of these communities (i.e., hypertension, diabetes, cardiovascular disease, etc.) can be directly linked to obesity.

In June 2001, the California Obesity Prevention Initiative (COPI) held a meeting with obesity experts throughout California to discuss issues of obesity and to brainstorm intervention strategies for a statewide obesity prevention plan. There was inadequate representation of the opinions of communities of color at the planning session, prompting COPI's decision to conduct meetings with African Americans and Latinos throughout the state. Ten community meetings were held in Sacramento, Oakland, Fresno, Los Angeles, Long Beach, and San Diego. This document summarizes the meeting findings, describes the underlying factors that contribute to obesity and being overweight among African Americans and Latinos, and examines the barriers to preventing obesity in these populations.

The findings from these meetings point to an ongoing need for culturally sensitive remedies for addressing obesity within communities of color. Issues of access, economics, deep-rooted cultural norms, mental health, social support, and the lack of culturally and linguistically sensitive medical resources continue to pose significant barriers for both the African-American and Latino communities.

Of particular concern for the Latino community is the lack of bicultural/bilingual medical, social service, and health education providers able to communicate obesity prevention information effectively.

Due to the different cultural backgrounds of the African-American and Latino communities, their perceptions of obesity need to be understood when developing programs. Mainstream definitions and images of what constitutes a "healthy" and attractive weight do not reflect what is felt in these communities. African Americans and Latinos tend to appreciate more curvaceous and "substantial" body types. Sensitivity is required in discussion of cultural perceptions versus medical definitions of body weight.

Briefly highlighted below are obesity prevention strategies suggested by meeting participants that they believe could be effectively implemented in their communities. In order to ensure successful outcomes within African-American and Latino communities, it is necessary to consider the specific issues and cultural norms identified by meeting participants when developing obesity prevention programs. Please note, that while we have chosen to highlight some of the important findings of the community meetings here, readers are strongly encouraged to read the full text to obtain an accurate portrait of the obesity issues faced by the African-American and Latino communities within California. The following information has been integrated into COPI programming and into its statewide obesity prevention plan.

African-American Community Meeting Findings

Contributing Factors

Meeting participants described many behavioral, cultural, environmental, and economic factors contributing to obesity in the African-American community. Participants spoke of the "sensitivity" many African Americans have around the whole discussion of weight and obesity. For many, that discussion represents just another painful, negative issue with which the community is faced. While the lack of physical activity and poor eating habits were identified as the most significant contributing factors, a multitude of other factors were cited as acting in concert with both of those issues. Some of these factors include:

- Overeating as a result of mental health issues (i.e., seeking relief or comfort from depression, stress, loneliness, low self-esteem, and racism).
- The inexpensive cost and accessibility of fast foods in urban neighborhoods.
- The lack of access to supermarkets in urban neighborhoods.
- The lack of safe locations to exercise.

Barriers to Obesity Prevention

Numerous barriers to obesity prevention were cited. The barriers were most often due to the lack of resources or to deficits in the environments where African Americans live. Some of the barriers cited include:

- Lack of culturally competent nutritional information specific to African Americans.
- Lack of access in inner city neighborhoods to supermarkets with healthy foods.
- Lack of safe places for children and families to exercise.
- Lack of child care.
- Deep-rooted cultural traditions.

Potential Interventions and Activities

The suggested interventions were classified in seven major categories: *Family Centered, Faith Based, Education and Awareness, Innovative Physical Activity, Food Purchasing and Preparation, Advocacy and Social Policy, and Social Support*. The following are just a few of the interventions and activities suggested by the meeting participants:

- Coordinate church sponsored farmers' markets.
- Coordinate family walking clubs.
- Develop a comprehensive "media blitz" (i.e., newsprint, radio, television, etc.) promoting obesity prevention within the African-American community.
- Work with beauty salons to sponsor classes teaching young African-American women and girls how to care for and maintain hairstyles to accommodate a more physically active lifestyle.
- Develop resources on adapting "soul food" recipes to "healthy soul food" recipes.
- Advocate to build major grocery store chains in inner city neighborhoods.
- Develop parent-run babysitting cooperatives that would allow parents the opportunity to exercise regularly.

Latino Community Meeting Findings

Contributing Factors

The most common factors contributing to obesity in the Latino community are:

- The pressure to assimilate (especially felt by kids) and do what other "American" kids are doing (eat processed foods and choose more sedentary activities).
- Social gatherings centered around food.
- Limited access to supermarkets with "healthy foods."
- Schools with unhealthy food selections.

Barriers to Obesity Prevention

Many barriers to obesity prevention were discussed. Most of the barriers were related to the lack of affordable, accessible, and appropriate resources in the Latino communities. Some specific barriers included:

- Lack of transportation or convenient mass transit.
- Lack of bilingual, culturally sensitive staff/providers.
- Lack of bilingual, culturally sensitive nutritional information.
- Lack of affordable child care.
- Lack of affordable organized sports or exercise programs for children and families.
- Deep-rooted cultural traditions and attitudes (e.g., the feeling that they are "destined to be overweight").

Potential Interventions and Activities

The suggested interventions were classified into five major categories: *Education and Awareness, Physical Activity, Food Purchasing and Preparation, Social Support, and School Based.* Following are a few of the interventions and activities suggested:

- Conduct a long-term, ongoing media campaign, supported by state and local governments, providing various, but consistent, obesity prevention messages with a toll-free telephone number and using Latino and Latina role models.
- Provide affordable parent/child sports, recreational activities (i.e., basketball, dance, yoga, etc.) or fitness programs in the early evening or during weekends.
- Conduct bilingual nutrition education programs that provide shopping tours, cooking demonstrations, and alternative/modified recipes to maintain traditional entrees.
- Develop *promotora* (community peers trained on specific topics) weight management programs.
- Coordinate a school advocacy committee through the Parent Teacher Association (PTA) to increase physical activity, provide nutrition education, eliminate vending machines and fast foods on campuses, and encourage healthy foods being served in the cafeteria.

One interesting point to mention about the participants is how they identified themselves ethnically. Participants were given a choice of checking Latino, Hispanic, or other. Most of the participants who identified themselves as Hispanic were over age 35 and those who identified themselves as Latino were under 32 years of age.

Recommendations

Recommendations to COPI for Future Activities in the African-American and Latino Communities

The following recommendations to COPI were generated by the meeting facilitators after a thorough review and analysis of the needs and issues identified by participants in the statewide community meetings. These recommendations suggest actions that COPI might consider in the areas of educational interventions, resource development, research, collaborations, and funding prioritization and allocation. COPI is in a unique position to assist in the development and promotion of obesity prevention infrastructures and practices that comprehensively and effectively address the needs of California's communities of color. COPI is urged to aggressively respond to and incorporate the meeting findings when creating and implementing statewide prevention activities targeting African-American and Latino communities.

The recommendations below have been categorized utilizing the *Spectrum of Prevention* model; a multifaceted, comprehensive approach to disease prevention that is currently being utilized by COPI to develop their statewide obesity prevention plan. This model shifts attention from individually focused health education to a systems approach by encouraging the linkage and coordination of multiple, simultaneously occurring prevention efforts. Recommendations are as follows:

Strengthening Individual Knowledge and Skills

- Develop educational materials that address the different subsets of the African-American community (i.e., women, parents, teens, men, and providers) to increase awareness regarding nutrition and physical activity, and ways to address/prevent obesity.
- Develop a statewide media campaign promoting proper nutrition and physical activity specifically targeting African Americans and Latinos.
- Develop bilingual educational materials that address the different subsets of the Latino community (i.e., women, parents, teens, men, and providers).

Promoting Community Education

- Host local discussion groups/public forums in African-American and Latino communities to further dialogue about the impact of the obesity epidemic within these communities.
- Develop a clearinghouse of resources and information regarding nutrition and physical activity that can be easily accessed by African-American and Latino communities.

Educating Providers

- Identify, disseminate, and encourage the replication of existing local and national obesity prevention interventions that have been shown to be successful with African-American and Latino communities.
- Develop a cultural competency protocol for medical providers to assist them in talking with their African-American and Latino patients about obesity, nutrition, and physical activity.
- Develop or identify paradigms for working with nontraditional African-American family structures (i.e., grandparents, single parents, extended family, etc.) and disseminate this information to obesity prevention providers working with the African-American community.

Fostering Coalitions and Networks

- Collaborate with other CDHS programs that are addressing other health-related diseases impacting African Americans and Latinos (i.e., prostate and breast cancer, cardiovascular disease, diabetes, tobacco use, etc.) to develop a comprehensive health campaign.
- Create and maintain two ongoing advisory bodies, comprised respectively of African-American and Latino providers, educators, community leaders, and community members to advise COPI on future activities.

Changing Organizational Practices

- Allocate substantial, long-term program funds for direct funding of African-American and Latino community-based organizations and nonprofit organizations to conduct obesity prevention activities.
- Work with statewide urban planning agencies and law enforcement agencies to create and promote "violence-free" family physical activity zones in parks and neighborhoods.

Influencing Policy and Legislation

- Develop a faith-based initiative that directly funds African-American faith communities to conduct obesity prevention activities.
- Fund research and pilot projects that seek to create truly effective and innovative obesity prevention interventions for African Americans and Latinos.
- Identify and fund mental health research that examines the relationship of the mental health needs of African Americans and Latinos with their obesity prevention needs.
- Develop an advocacy guide to disseminate to community agencies and parent advocacy groups that will assist them in working with schools to develop healthy policies regarding nutrition and physical activity.

Background

In June 2001, COPI held meetings with providers throughout California to discuss the issues of obesity and to brainstorm intervention strategies for the development of a statewide prevention plan. During the process, it was recognized that there was inadequate representation of the opinions of communities of color at the sessions. Recognizing this fact prompted COPI to hold ten community meetings with representatives from these populations throughout the state, to obtain their opinions about the most important contributing factors and barriers to the prevention of obesity in the African-American and Latino communities. Additionally, the meetings provided an opportunity to solicit ideas for specific obesity prevention strategies that could be effectively implemented in these communities.

Two meeting facilitators, one African American and one Latina, with experience facilitating strategic planning meetings, were identified and hired to plan and implement these meetings. The Latina facilitator was bilingual and was able to hold meetings in both English and Spanish. Both have a Masters in Public Health and extensive experience conducting community level activities.

The groups were categorized as either "community" or "professional" meetings. Community group meetings were defined as meetings primarily comprised of participants who were recipients of community-based services or who had no professional association with programs promoting nutrition, physical activity, or obesity prevention. Professional group meetings were defined as meetings primarily comprised of participants who either work in health care or who work in programs that conduct nutrition, physical activity, or obesity prevention activities with communities of color. Additionally, "professional" meeting participants also included those who worked in early child development or child health programs.

Meeting participants were recruited from a variety of locations with the assistance of COPI State Planning Group's contacts. In order to ensure participation, incentives were utilized to recruit participants of the community group meetings. The meetings were held in San Diego, Los Angeles, Long Beach, Fresno, Sacramento, and Oakland between July and September 2002.

Meeting Process Overview

Each meeting was approximately two hours in length. The meeting began with introductions and an icebreaker activity. The purpose of the icebreaker was to give the facilitators a visual framework of how the meeting participants described and perceived certain body types. Participants were shown pictures and were asked to describe the people appearing in the pictures with whatever adjectives came to mind. After completing this activity, the groups were then guided through a series of discussion questions regarding the contributing factors, cultural determinants, and barriers to preventing obesity in their communities. The participants were also asked to establish criteria by which to prioritize interventions and then suggest interventions that they felt would be effective in reaching their respective ethnic communities. Upon completing the discussion segment of the meeting, participants were then given a questionnaire to obtain demographic information. These questionnaires were to determine the participants' personal assessment of their own needs regarding obesity and physical fitness. The meeting concluded with participant incentives in the form of a $25 gift certificate to each community participant.

African-American Community Meetings

Meeting Participant Characteristics

A total of five meetings were held with the African-American community and involved a total of 71 participants. These participants included 23 men and 48 women. The average age of the participants was 47, with a range of 12–78 years old. The participant questionnaires indicated that among the meeting participants, 5 (7 percent) completed 12 years of school or less, 9 (13 percent) completed community college, 24 (35 percent) had college degrees, 21 (30 percent) had graduate degrees, and 10 (14 percent) had professional degrees. Regarding the marital status of participants, 30 (42 percent) were married, 27 (38 percent) were single, 12 (17 percent) were divorced, and 2 (3 percent) were widowed. The average number of children reported by parenting participants was approximately three.

When asked about their personal assessment of their own weight and their challenges in maintaining a healthy weight and physical activity, the most often cited responses were as follows:

Question #1

Do you consider yourself to be overweight?

- 31 (46 percent) indicated yes
- 33 (48 percent) indicated no
- (6 percent) indicated somewhat/slightly

Question #2

What are your main challenges/ barriers to maintaining a healthy weight and regular exercise?

- No time
- Bad eating habits
- No physical activity
- Inconsistency
- No support system/network
- Stress

Question #3

What would you need to help you maintain a healthy weight?

- Increased exercise
- A support system/network
- More commitment
- To eat better
- More time
- Information on nutrition

Question #4

What steps could you take personally to maintain a healthy weight?

- Eat healthier foods (i.e., fruits and vegetables)
- Increase physical activity
- More consistency
- Cut down on fattening foods and sweets

Summary of Findings

The following is a comprehensive summary of the information garnered at the five meetings held with African Americans. Due to a tremendous amount of similarity and consistency in opinions and ideas presented, regardless of meeting location or category (i.e., community vs. professional meeting), the summary of findings is a compilation of all of the group discussions.

Perceptions of Obesity

Many participants felt that there was very little or no consensus in the African-American community regarding the definition of obesity. However, they agreed that neither traditional medical definitions nor standard BMI charts were appropriate when describing overweight African Americans. The participants felt that those criteria did not accurately nor fairly describe their weight and that the definitions would be best described in terms of one's health status. For example, they felt that if someone was considered heavier than they should be, but was healthy and physically active, they should not be considered obese or overweight. Some people described being obese/overweight as being when one felt uncomfortable (e.g., sore knees, backaches, shortness of breath, etc.) or exhibited other physical problems due to being overweight (e.g., diabetes, hypertension, etc.). Additionally, several meeting participants spoke of the "sensitivity" many African Americans have around the whole discussion of weight and obesity. For many, that discussion represents just another painful, negative issue with which the community is faced.

> ***"I'm not sure that the African-American community can define being obese. I'm not sure that the community has a handle on it…"***
>
> SACRAMENTO PARTICIPANT

Terminology Describing Obesity or Being Overweight

Participants shared many colorful terms and expressions used by African Americans to describe being obese or overweight. They stated that the word obese is very rarely used when describing body type. As one participant noted, the words used to describe overweight African Americans very rarely carry negative connotations and in the case of the word "healthy" can even be an oxymoron. This phenomenon was generally associated with the fact that African Americans do not necessarily find someone with a little extra weight as unattractive. One participant noted, "African-American men like a woman with a little meat on her bones."

Examples of the terms used include:

- Big-boned
- Thick
- Built
- Heavy-set
- Healthy
- Pleasingly plump
- Solid
- Full-figured
- Chunky
- Stocky
- Sturdy
- Stacked
- Bootylicious
- "She's got meat on her bones"
- "She's got junk in her truck"

"It's cheaper on Tuesdays to buy 39 cent hamburgers at McDonald's than to fix a salad."

ANONYMOUS

Contributing Factors to Obesity and Being Overweight

Meeting participants described many behavioral, cultural, environmental, and economic factors contributing to obesity in the African-American community. While the lack of physical activity and poor eating habits were identified as the most significant contributing factors, a multitude of other factors were cited as acting in concert with both of these issues. Inexpensive and accessible fast food, the lack of access to supermarkets in urban neighborhoods or to supermarkets carrying quality fruits and vegetables, and the lack of safe locations to exercise were also often cited as contributing to overweight.

Deep-rooted cultural traditions, such as cooking and eating "soul food" at family and social gatherings, play a tremendous role in causing unhealthy weight among African Americans. In African-American social traditions, showing "hospitality" to one another was often done through the sharing of food. As pointed out by one participant when speaking of this tradition, "If we had nothing else, we had food." Additionally, growing up with parents or grandparents saying things such as, "Eat everything on your plate because there are children starving in Africa," also resonated with many participants.

There was much discussion about the fact that these traditional eating patterns were established long ago, when African-Americans had little choice about what kinds of foods they could eat. Slavery and segregation dictated that African Americans had to learn to make do with, as one participant described as "throw away or scrap" foods. African Americans learned to make those foods taste good by adding significant amounts of fat, sodium, and sugar. But participants importantly noted that these ancestral eating habits are no longer accompanied by the strenuous manual labor associated with previous generations.

"We don't have time. We have so many other stressors that sore ankles or pants being too tight is the least of what we have to deal with."

OAKLAND PARTICIPANT

The threads of the multitude of psychosocial issues faced by African Americans were woven throughout meeting discussions. Participants felt that mental health issues are too often overlooked and that they must be addressed in programs hoping to prevent obesity.

Those seeking relief or comfort from depression, stress, loneliness, low-self esteem, and racism often find it in food. The term "soul food" perfectly illustrates the psychological and emotional role food and eating often play in the lives of African Americans. As one participant stated, "Culturally, food is a reward. It feeds our sorrow and it feeds our joy."

Additionally, the predominance of single mother households in the African-American community and the enormous role these mothers must play as primary caretakers gives them little time to focus on their own health and wellness. Some of them alleviate or soothe the emotional stress of raising children, not having mates, and managing other critical life challenges through overeating.

> ***"The kids I taught last year in South Central, they live in apartments and their parents are scared for them to go out and play; they have to stay in confined areas."***
>
> LOS ANGELES PARTICIPANT

Barriers to Obesity Prevention

Numerous barriers to obesity prevention were cited. Most of the barriers were related to the lack of resources or to deficits in the environments where African Americans live. One participant shared that when her church did a neighborhood needs assessment for a nutrition grant they were writing, they found that there was one supermarket compared to 17 fast food restaurants within a two-mile radius of the church. Additionally, the lack of safe and affordable places to exercise was also consistently identified as a barrier. Other barriers include:

- Lack of culturally competent nutritional information specific to African Americans.
- Lack of access in inner city neighborhoods to supermarkets with healthy foods.
- Healthy foods are more expensive than junk food.
- Excessive portion sizes served by restaurants.
- Lack of safe places for children and families to exercise.
- Lack of child care.
- Lack of self-recognition of being obese.
- High cost of organized sports for children.
- Lack of self-esteem.
- Deep-rooted cultural traditions.
- Self-denial of the impact of obesity on one's own life.
- Too many responsibilities and not enough time.

Suggested Interventions and Activities

Meeting participants were asked to brainstorm lists of potential interventions that they felt would be successful in the African-American community. The meeting facilitator designated the categories, in which the following interventions are grouped, after completing the meetings and noting consistent themes of interventions suggested at each meeting.

> ***"We have moved from the family value of sitting down and eating together. We need to take the time to sit at the table and graciously eat a meal rather than eat on the run."***
>
> LOS ANGELES PARTICIPANT

Family Centered

There were several suggestions for family-centered interventions. Participants often cited the lack of child care and lack of time as barriers to participating in certain activities. Participants felt that they may be able to be more successful and consistent if activities facilitated involvement of the whole family. This type of intervention would be particularly meaningful for single parent homes. Activities suggested include:

- Mother/daughter walking and dance groups.
- Family fitness and health clinics on Saturdays.
- Father/son sports activities.
- Family walking clubs.
- Encourage eating as families at mealtime.

Faith-Based

Meeting participants discussed the historical significance of churches and faith communities in the lives of African Americans. In times past, not only were they places for worship, but they were also places from which people sought information and services. Due to the trust they hold with African Americans and the availability of consistent audiences, faith communities would be uniquely poised to conduct innovative obesity prevention activities with the community. Some of the suggested activities are as follows:

- Develop church-sponsored support groups for overweight teens.
- Conduct church-sponsored farmers' markets.
- Encourage churches to purchase and operate neighborhood grocery stores that provide healthy food choices.
- Conduct church-sponsored exercise and nutrition programs.
- Work with neighborhood gyms to donate exercise time to church members.

"For me, one of the major issues is that many of us don't have access to the educational information that we need in order to set those kinds of things right."

FRESNO PARTICIPANT

Education and Awareness

While participants felt that African Americans had a fair amount of access to nutritional and physical activity information, they felt that there were still many gaps and needs in the areas of education and awareness. They all felt that comprehensive media campaigns could play an important role in getting the word out to the African-American community. Participants wanted to see both local and national African-American media utilized to tackle the issues. Additionally, they felt that there was a lot of dialogue around obesity prevention that could happen at both the individual and community levels. Suggestions were as follows:

- Host facilitated African-American conversation groups/forums to discuss issues of obesity.
- Conduct a comprehensive "media blitz" (i.e., newsprint, radio, television, etc.) promoting obesity prevention within the African-American community.
- Educate African-American gatekeepers (i.e., ministers, community leaders, social clubs, etc.) about the issue of obesity.
- Conduct comprehensive research focused on creating effective interventions, not just identifying the problems.
- Identify programs that are already working and systematically disseminate information regarding those programs to other communities.
- Have a well-known African-American celebrity promote a fitness campaign.
- Encourage African-American newspapers, radio stations, and television to address obesity and physical activity through media advocacy.
- Teach medical providers how to have a dialogue with patients that helps them capitalize on opportunities for behavioral intervention in different areas of their daily lives.

"How do you undo something that's been ingrained in you ever since you can remember? That's probably the biggest challenge facing the whole project."

LOS ANGELES PARTICIPANT

"If I've just got my hair done, I'm not going to sweat my hair back."

SACRAMENTO PARTICIPANT

"We tend to eat for taste, not for health."

OAKLAND PARTICIPANT

Physical Activity

Participants were very aware of the need for the community to increase its level of physical activity but noted many factors that stand in the way of that being done. There is a definite need to develop approaches to exercise that are more appealing and enjoyable to African Americans. One of the most poignant issues discussed at each of the meetings was that of African-American women not wanting to get their hair wet, from water or sweat, when exercising. African-American women expend a lot of resources, both time and money, getting their hair done. They are very hesitant to waste those resources by messing up their hair exercising. They do not want to sweat and have their hair return to its "natural" state. Activities suggested were as follows:

- Work with beauty salons to sponsor classes teaching young African-American women and girls how to maintain their hair for exercising.
- Encourage African-American women's magazines (e.g., Essence) to feature articles about how to style and maintain hair for exercise.
- Provide African, Salsa, and Brazilian dance classes at community centers.
- Provide Hip-Hop aerobic classes.
- Train more African Americans on how to teach exercise activities.
- Sponsor community and worksite walking clubs/groups.
- Produce Afro-centric exercise tapes or DVDs.

Food Purchasing and Preparation

There was much discussion about the fact that many African Americans eat out often instead of cooking. Participants spoke of the days of when young people would sit in their mothers' kitchens to watch them and learn how to cook. Today that rarely happens, and many young people do not know how to cook. This has resulted in there being a number of young parents who feed themselves and their children fast foods and/or microwave meals. Moreover, when African Americans do cook they are often still utilizing ingredients that are unhealthy and fattening. There were several innovative suggestions for interventions that could assist with the purchasing and preparation of healthy food:

- Integrate food preparation and nutrition classes into Welfare to Work programs.
- Provide healthy cooking classes to young mothers.
- Advocate for a return of home economic classes in schools.
- Station health educators/nutritionists in neighborhood grocery stores to educate on healthy food choices.
- Develop resources or classes on adapting "soul food" recipes to "healthy soul food" recipes.
- Develop classes that teach people how to read and understand food labels.
- Conduct a mentor program where people shop and cook healthy foods together.

Advocacy and Social Policy

The meeting participants were acutely aware that there are many things that could be done at the policy level to complement and enhance community and individual level interventions. Many of the following suggestions address the environmental and societal issues impacting communities:

- Litigate the fast food industry
- Lobby the fast food industry to show people doing physical activities in commercials
- Require warning labels for fast food and junk food
- Sponsor "No Fast Food" months
- Lobby for fewer liquor stores in poor neighborhoods
- Advocate for less fast food restaurants in inner city neighborhoods
- Advocate for major grocery store chains to build in inner city neighborhoods
- Build capacity of neighborhoods including churches, community-based organizations, and other community venues to address obesity through coalition building and resource development
- Advocate for schools to develop healthy policies regarding nutrition and physical activity

Social Support

One of the most consistently identified needs of the community was that of social support. Many people cited the need for networking and the sharing of resources to help them begin and maintain healthy behaviors. Additional social support needs identified include:

- Develop buddy programs or exercise support groups.
- Host summer empowerment camps for overweight teens.
- Conduct workshops that encourage self-empowerment and goal setting.
- Provide affordable or no cost child care as part of physical activity interventions.
- Develop parent-run babysitting cooperatives that would allow parents the opportunity to exercise regularly.

Criteria for Selecting Interventions

The groups were asked to determine a set of criteria for selecting/determining interventions that would be most effective at reaching the African-American community. Overwhelmingly, the participants stressed that it is critical for the target audience to be involved at the onset and in each stage of the development and implementation of interventions. The following criteria for selecting interventions were often cited by meeting participants:

- Should always involve input from target audience in the prioritization and creation of the interventions
- Should be culturally appropriate
- Should have a holistic approach and have multiple benefits to the audience
- Should give participants a sense of empowerment
- Should be easy/doable/attainable/realistic
- Should be sustainable, long-term efforts
- Should be inexpensive/affordable
- Should have the "buy in" of the community and community leaders
- Should be integrated/combined with addressing other health issues
- Should be conducted in locations/environments where the audience feels comfortable (i.e., their churches, social clubs, neighborhoods, etc.)
- Should reduce the barriers encountered by the audience

Other suggested criteria included:

- Should have the necessary financial and human resources needed to ensure success
- Should have language and tone that is nonjudgmental of the audience (African Americans do not need to feel that they are failures or wrong for not being fit)
- Should be conducted with "captive" or already existing groups
- Should be skills based (hands on) and involve goal setting
- Should combine nutrition education with physical fitness
- Should have realistic timelines to achieve changes (audience should not be pushed just to meet provider timelines)
- Should reach large numbers of African Americans
- Should be tailored to individuals
- Should increase psychosocial support

Potential Partnerships/Collaborations/ Spokespersons

Meeting participants were asked which partners should be included to ensure successful interventions. They were also asked who they felt African Americans trust in their communities. Responses included the following:

- Ministers and churches
- T.D. Jakes (a well known and respected African-American minister who has recently lost a lot of weight and changed his nutritional habits)
- Black Women's Health Project
- Community-based and nonprofit organizations
- Senior citizens groups
- African-American celebrities
- African-American celebrity athletes (Serena and Venus Williams, Shaquille O'Neal, etc.)
- School teachers
- Child care providers
- African-American sororities and fraternities
- African-American organizations (i.e., National Association for the Advancement of Colored People, Urban League, 100 Black Men, Council of Negro Women, etc.)
- Service agencies (WIC, food banks/ closets, general assistance agencies, etc.)
- Parks and recreation programs
- Local and national African-American media outlets

Potential Barriers Providers May Encounter

When asked about potential barriers or concerns agencies providing services might encounter when implementing interventions with the African-American community, participants emphasized the importance of agencies having an understanding of the economic, cultural, and psychosocial backdrop of the communities they are attempting to serve. Trying to undo highly ingrained cultural traditions and behaviors in certain communities can be a daunting task and must be approached with sensitivity and cultural compassion. Additionally, there is a high potential for distrust of the new projects if the people implementing the projects are not African American or not culturally sensitive and aware. The community will not embrace the projects and providers if they do not trust them.

Finally, the lack of resources in some communities could present particularly significant barriers. One meeting participant recounted her experience of trying to develop an "Aqua Boogey" water aerobics class for African-American women. She had the format for the class and willing and enthusiastic participants, but was unable to find and secure a pool in the neighborhood at which to hold the class. Projects must have the necessary resources in place or identified if they hope to be successful.

Latino Community Meetings

Meeting Participant Characteristics

A total of five meetings were held with the Latino community and involved a total of 59 participants. These participants included eight men and 51 women. The average age of the participants was 39, with a range of 18–74 years old. The survey indicated that among the meeting participants 16 (27 percent) completed 12 years of school or less, 28 (47 percent) had college degrees or received technical training certificates, and 15 (26 percent) had graduate degrees. Regarding the marital status of participants, 19 (32 percent) were single, 34 (58 percent) were married, 5 (8 percent) were divorced and 1 (2 percent) was widowed. The average number of children reported by parenting participants was three.

One interesting point to mention about the participants is how they ethnically identified themselves. Participants were given a choice of checking Latino, Hispanic, or other. Of the 59 participants, 14 (24 percent) identified themselves as other (White or Mexican). Of the remaining participants, almost equal amounts identified themselves as Latino 23 (39 percent) or Hispanic 22 (37 percent). Most of the participants who identified themselves as Hispanic were over age 35, and those who identified themselves as Latino were under 32 years of age. Some participants were very defensive about identifying their ethnicity. It would be important for any agency to clarify from the community they will serve what ethnic identification is acceptable and preferred.

When asked about their personal assessment of their own weight and their challenges in maintaining a healthy weight and physical activity, the most often cited responses were as follows:

Question #1

Do you consider yourself to be overweight?

- 36 (61 percent) indicated yes
- 16 (27 percent) indicated no
- 7 (17 percent) indicated somewhat/slightly

Question #2

What are your main challenges/ barriers to maintaining a healthy weight and regular exercise?

- No time
- No motivation
- No exercise
- No child care
- No transportation
- Lack of knowledge

Question #3

What would you need to help you maintain a healthy weight?

- Motivation
- More time
- Increased physical activity
- A support system
- Worksite exercise programs
- Access to low cost gyms
- Exercise programs for whole family
- Eat healthy foods
- Diet class/counseling/plan

Question #4

What steps could you take personally to maintain a healthy weight?

- Eat healthy foods (e.g., fruits and vegetables)
- Increase physical activity
- Manage/prioritize time to exercise
- Attend health classes/counseling

Summary of Findings

The following is a comprehensive summary of the information compiled at the five meetings held with Latinos. There were many similarities and consistency in opinions and ideas presented, regardless of meeting location or representation of the group (i.e., community vs. professional meeting).

Perceptions of Obesity

According to some participants, the Latino community thinks being overweight is acceptable. This is particularly true for Latinas, especially if grandma *(abuelita)*, mother, and aunt *(tía)* are overweight. Therefore, Latinas are not supported when trying to stay healthy because they have been cursed with the "fat genes." In other words, for some Latinas it is their destiny to be overweight; thus, there is nothing they can or should do to prevent it. It was noted that some Latinos think that a thin Latina would have more problems getting pregnant; therefore, a Latina who is "*poquita gorda*—a little fat" is preferable. It was also stated that, "Not only is a chunky child *(gordito)* acceptable, but is cuter."

> ***"Un niño gordito es más saludable que un niño delgado que siempre es enfermo."*** **("A chubby child is healthier than a thin child who is always sick.")**
>
> SACRAMENTO PARTICIPANT

Terminology Describing Obesity or Being Overweight

Overall, the meeting participants were consistent in identifying terms used to describe someone who is overweight. Some of these terms include:

- *Gorda* (Fat)
- *Gordito/a* (Can be used as a term of endearment "little fat one" or used to describe overweight children)
- *Hermosa* (Can be used as a term of endearment similar to "Big and Beautiful")
- *Sobrepeso* (Overweight)
- *Pasado de peso* (Overweight)
- Chunky
- Chubby
- Husky (Often used more to describe men and children)
- Stocky
- Solid
- Heavy
- Heavy set
- Big-boned
- Plump
- Full figured
- Large

Contributing Factors to Obesity and Being Overweight

One of the most common cultural factors contributing to obesity in the Latino community is the many social gatherings centered around the consumption of food. As one participant commented, "Large Latino families mean more parties." Another participant stated that, "We were taught to never show up to a party empty handed. You must bring enough food to feed everyone or else!" The majority of the participants agreed that portion sizes are much larger than what should be eaten. And many of these foods are high in fat and calories. It was felt that Latinos are not aware of healthy cooking alternatives. Food is a comfort item and as one participant stated, "We show our affection by providing food and to reject it is not only disrespectful, but you're denying the affection."

"We live to eat, not eat to live!"

LOS ANGELES PARTICIPANT

Many participants felt that the pressure to assimilate, especially for kids, is another significant factor contributing to obesity. It was noted that first and second generation kids are eating and doing what other "American" kids are doing. Since many Latino parents want their kids to "fit in," they buy fast food, processed foods (e.g., Twinkies, Lunchables, etc.), and video games. Also, there are more latch-key kids and since some communities are not safe, parents are forced to give into modern technology. This means kids must stay indoors watching TV or playing video games. Thus, Latino kids are eating unhealthy foods and not getting enough physical activity. There was a general consensus that many healthy lifestyles are lost or given up when families move from Mexico to the United States. "For example, in Mexico, many families walk everywhere, eat fresh fruit and vegetables everyday, and eat meat on special occasions. Overweight children are rarely seen in Mexico."

"I'd rather get six hours of sleep than lose an hour by exercising."

SAN DIEGO PARTICIPANT

The majority of the participants agreed that there is just not enough time in a day. With the need for both parents to work, there is no time to shop for food, cook, and clean up. It is easier to buy and make processed foods or eat out. Even stay at home moms reported not having time. They are too busy cleaning house, running errands, taxiing kids around, or helping with homework. "Women sacrifice themselves for their family." This means women have less time for themselves, thus, no time to exercise. With limited time, daily activities have to be prioritized and exercise is often not a priority. Furthermore, as one participant stated, "Latinos are not used to structured, planned physical activity." She went on to explain that a lot of jobs that Latinos are doing require manual labor and many feel that there is no need to do more exercise, especially after a long day at work.

"I cannot afford to put all four of my kids in sports, nor do I feel safe leaving two at one park to be with the other two at another park."

SACRAMENTO PARTICIPANT

Many participants felt it was difficult to start and maintain an exercise/diet program due to the lack of motivation. One reason is the lack of support. A support system, whether another individual or group, is important to encourage a healthy lifestyle, acknowledge progress, and offer advice. "It is difficult to find someone who has a similar schedule and

willing to exercise with me," stated one participant. Many meeting participants reported not knowing how to start a support group or look for one. There are too many temptations and not enough will power, especially for mothers. It is tempting to eat kids' leftover food or other unhealthy food around the house. "It is easier to gain weight than to lose it. It takes too long to lose weight and see a difference," stated one participant.

There are also limited products and services available to help maintain a healthy weight. Several participants pointed out that there are a lot of "mom and pop" stores in Latino communities and these small stores do not carry fresh, healthy, affordable foods. In addition, there are few affordable, accessible, and safe gyms/community centers that kids and adults can utilize. Furthermore, there are even fewer programs that offer activities where parents and children can participate together.

"Since most kids eat the majority of their meals at school (breakfast, lunch, and snacks), schools need to set an example and provide healthier options."

SAN DIEGO PARTICIPANT

Another contributing factor to obesity is the fast food industry. As one participant stated, "The increased access to fast foods, enticing commercials, and competitive daily specials is difficult for any busy, tired mom with cranky, hungry kids to resist." Many participants felt that the media (e.g., TV, radio, billboards, magazines, etc.), especially Spanish media, has a strong influence on eating unhealthy foods. Several messages include bigger is better ("Biggy," "King Size," "Mighty Meals," etc.) and processed foods are "cool" and more convenient; however, these are often high in fat and sugar.

Participants also expressed a concern and disappointment in the school system, which appears to give a low priority on healthy eating. School lunches are high in fat and sugar and offer/provide few fruits and vegetables. Many schools support candy and soda vending machines and fast food restaurants on campus. Also, many nutrition education and home economics classes have been cut. Thus, those parents who are trying to keep their children healthy are not supported.

Another factor is the lack of trust. A number of agencies (i.e., clinics, hospitals, community based organizations, etc.) require a lot of personal information before rendering services. Many Latinos do not understand why personal information is needed and are not used to giving it out. Many fear being reported or discriminated against. This is especially true for agencies that do not have bilingual and culturally sensitive staff. As one participant stated, *"Me siento más comfortable si me hablan en español para ayudarme*—I would feel more comfortable if the person who was helping me speaks Spanish."

Finally, many participants questioned whether obesity in the Latino community is associated with mental health issues. There are few mental health resources and participants are not confident that those few are capable of understanding or providing services for the Latino community. "Many Latinos have a lot of life stressors and do not know how to handle them. It is not acceptable to be diagnosed with a mental health problem or receive treatment." Some Latinos deal with these life stressors by overeating.

Barriers to Obesity Prevention

Many barriers to obesity prevention were discussed. Most of the barriers were related to the lack of affordable, accessible, and appropriate resources in the Latino communities. Specific barriers included:

- Lack of transportation or convenient mass transit
- Lack of bilingual, culturally sensitive staff/providers
- Lack of bilingual, culturally sensitive nutritional information
- Lack of access to supermarkets with "healthy foods"
- Lack of safe places for children and families to exercise
- Lack of affordable child care
- Lack of affordable, organized sports and/or exercise programs for children and families
- Lack of self-esteem
- Deep-rooted cultural traditions and attitudes (the belief that they are "destined to be overweight")

Suggested Interventions and Activities

Meeting participants were asked to brainstorm lists of potential interventions that they felt would be successful in the Latino community. The meeting facilitator designated the categories, in which the following interventions are grouped, after completing the meetings and noting consistent themes of interventions suggested at each meeting. The intervention activities are described below.

> ***"My mother thinks that vitamins are taken out of low fat milk."***
>
> SAN DIEGO PARTICIPANT

Education and Awareness

Participants felt that obesity education and awareness interventions are most needed to bring obesity prevention to the forefront. These interventions could also help dispel a lot of misconceptions that many Latinos have about low fat and "light" products. It was stressed that intervention messages must be culturally and linguistically appropriate and realistic to be successful. Some suggested education and awareness interventions included:

- Conduct a long-term media campaign, supported by state and local governments, providing various but consistent obesity prevention messages with a toll-free telephone number and using Latino and Latina role models.
- Conduct a long-term media campaign developed by teens, supported by state and local governments, providing various but consistent obesity prevention messages with a toll-free telephone number and using Latino and Latina teen role models.
- Provide low cost weight management programs for adults and children with access to bilingual resources (i.e., nutrition counselor and education material).
- Enhance the Expanded Food Nutrition Program (EFNP).
- Provide obesity prevention and sensitivity training to health professionals (e.g., doctors, nurses, counselors, etc.).
- Provide self-esteem and empowerment workshops for adults and children.

Physical Activity

Participants often identified the need for activities that involve the whole family. Not only should these activities be appropriate for all ages, but they should also be affordable and convenient as well. Additionally, because many parents work, there was a strong suggestion for employers to support and implement exercise programs in the workplace. Many felt that in the long run not only would the employee benefit, but the employer as well, by having healthy more productive staff. Some ideas for physical activity programs included:

- Coordinate walking groups around parks, schools, and malls in the early morning or late evenings and accommodate children.
- Provide parent and child sports or recreational activities (e.g., basketball, dance, yoga, etc.) or fitness programs in the early evening or weekends.
- Develop worksite physical activity programs.

Food Purchasing and Preparation

Participants felt that many Latino men and teens do not know how to cook. Therefore, cooking and nutrition programs that could reach these groups before they become parents could help the Latina mothers later from feeling overwhelmed. Many participants also felt that many Latinos are not aware of how to prevent obesity. "Thus, many Latinos are not aware of long-term consequences. Many think high-fat foods are more nutritious." Some food purchasing and preparation suggestions included the following:

- Conduct bilingual nutrition education programs that provide shopping tours and cooking demonstrations to learn how to modify recipes to maintain traditional entrees.
- Provide cooking, shopping, parenting, and housecleaning classes specifically for men.
- Develop an "*Abuelita's cocina*" (Grandma's kitchen) where the elderly men and women are taught to modify traditional recipes and share with young parents.

Social Support

Many Latinos do not know who to ask for assistance to help them with weight management. Many Latinos are also trying diet and exercise programs that are "quick fixes," but give them no support for long-term maintenance. Psychosocial services have to be available and sensitive to the weight management goals of the individual. Some ideas for social support were:

- Develop promotora (community peers trained on specific topics) weight management programs.
- Develop screening programs for mental health and offer appropriate training and referrals.

School-Based

Participants felt that at one point schools were on the right track by offering home economic classes and more time for physical activity at recess and during physical education classes, but the priorities seemed to have changed. "Schools have to get back to basics and support healthy children." Strong advocates are needed to mobilize schools for some basic and innovative programs such as the following:

- Coordinate a school advocacy committee through the PTA to increase physical activity, provide nutrition education, replace "junk foods" in the vending machines with healthy snack foods, eliminate fast foods on campuses, and encourage healthy foods being served in the cafeteria.
- Develop Latina teen weight management programs and encourage other Latina teens to mentor support groups.

Criteria for Selecting Interventions

The groups were asked to determine a set of criteria for selecting interventions that would be most effective at reaching the Latino community. The criteria for selecting interventions are as follows:

- Should be affordable
- Should provide bilingual staff and resources
- Should be accessible (i.e., convenient location, various and extended hours of operation, etc.)
- Should respect Latinos and promote a safe and trusting environment
- Should be culturally appropriate and realistic
- Should offer consistent services and promote consistent messages
- Should be dedicated to sustaining successful interventions within the community

Potential Partnerships/Collaborations/ Spokespersons

Meeting participants were asked which partners should be included to ensure successful interventions. They were also asked who they felt Latinos trust in their communities. Responses included the following:

- Schools and school districts
- Local coalitions
- Latino 5 A Day Program
- Local Proposition 10 Commission
- Faith community
- Resource centers
- City and county parks and recreation departments
- Media, such as TV/radio
- Programs that serve parents with young children (i.e., WIC, foster care, children's protection services, child care providers, etc.)
- Politicians
- Business owners
- Clinics/hospitals
- Physical therapy offices
- Agencies that provide services to migrant farm workers

> ***"Programs must be AAA (Affordable, Accessible, and Appropriate)."***
>
> FRESNO PARTICIPANT

Potential Barriers Providers May Encounter

The most common concerns the participants had for any agency conducting obesity prevention activities are that programs need to be affordable and accessible. This means the ability for a family (of at least four) to participate in activities on a regular basis. It also means these programs would be in convenient locations, possibly even within walking distance from home, and offer various and extended hours of operation. Since transportation is an issue, agencies need to arrange for safe pick up and drop off, especially for kids, the elderly, and families in rural communities. A number of meeting participants agreed that programs that lack bilingual/bicultural resources could be a significant barrier. Agencies must involve the community for ideas and hire them to work in these programs. One participant stated, "It is vital to hire staff who are bilingual and culturally sensitive." This would assist the agency in planning and implementing a realistic program. "Programs would be more successful in promoting and modifying traditional foods rather than foods Latinos are unfamiliar with or resistant to try." Participants felt the support from the community is crucial in making programs work. Finally, agencies with a history of short-term projects or not planning ahead could be met with a lot of resistance and distrust. "With any program, agencies need to determine and plan strategies to sustain activities."

Appendix III

Healthy People 2010 Objectives for Reducing Overweight and Obesity

Healthy People 2010 is the prevention agenda for the nation. It is a valuable tool for health planners, medical practitioners, educators, elected officials, and all who work to improve health in this country. Healthy People 2010 includes over 467 objectives that are based on the best scientific knowledge. The objectives are designed to measure programs over time. By selecting from the national objectives, individuals and organizations can build an agenda for community health improvement, which can be monitored for results over time. The following objectives were selected because of their impact on the issues of overweight and obesity.

Healthy People 2010 Objectives for Reducing Overweight and Obesity

http://www.health.gov/healthypeople/

Weight Status and Growth

- 19.1 Healthy weight in adults
- 19.2 Obesity in adults
- 19.3 Overweight or obesity in children and adolescents
- 19.4 Growth retardation in children

Schools, Worksites, and Nutrition Counseling

- 19.15 Meals and snacks at school
- 19.16 Worksite promotion of nutrition education and weight management
- 19.17 Nutrition counseling for medical conditions

Access to Quality Health Services

- 1.3 Counseling about health behaviors

Diabetes

- 5.1 Diabetes education
- 5.2 New cases of diabetes
- 5.6 Diabetes-related deaths

Educational and Community-Based Programs

- 7.2 School health education
- 7.5 Worksite health promotion programs
- 7.6 Participation in employee-sponsored health promotion activities
- 7.10 Community health promotion programs
- 7.11 Culturally appropriate and linguistically competent community health promotion programs

Health Communication

- 11.4 Quality of Internet health information sources

Maternal, Infant, and Child Health

- 16.10 Low birth weight and very low birth weight
- 16.12 Weight gain during pregnancy
- 16.19 Breastfeeding

Physical Activity and Fitness

- 22.1 No leisure-time physical activity
- 22.2 Moderate physical activity
- 22.3 Vigorous physical activity
- 22.6 Moderate physical activity in adolescents
- 22.7 Vigorous physical activity in adolescents
- 22.9 Daily physical education in schools
- 22.13 Worksite physical activity and fitness

Description of Healthy People Objectives

Healthy People 2010

http://www.health.gov/healthypeople/

Weight Status and Growth

- 19.1 Increase the proportion of adults who are at a healthy weight.
- 19.2 Reduce the proportion of adults who are obese.
- 19.3 Reduce the proportion of children and adolescents who are overweight or obese.
- 19.4 Reduce growth retardation among low-income children under age five years.

Schools, Worksites, and Nutrition Counseling

- 19.15 Increase the proportion of children and adolescents aged six to 19 years whose intake of meals and snacks at school contributes to good overall dietary quality.
- 19.16 Increase the proportion of worksites that offer nutrition or weight management classes or counseling.
- 19.17 Increase the proportion of physician office visits made by patients with a diagnosis of cardiovascular disease, diabetes, or hyperlipidemia that include counseling or education related to diet and nutrition.

Access to Quality Health Services

- 1.3 Increase the proportion of persons appropriately counseled about health behaviors.

Diabetes

- 5.1 Increase the proportion of persons with diabetes who receive formal diabetes education.
- 5.2 Prevent diabetes.
- 5.6 Reduce diabetes-related deaths among persons with diabetes.

Educational and Community-Based Programs

- 7.2 Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following areas: unintentional injury, violence, suicide, tobacco use and addiction, alcohol and other drug use, unintended pregnancy, HIV/AIDS and STD infection, unhealthy dietary patterns, inadequate physical activity, and environmental health.
- 7.5 Increase the proportion of worksites that offer a comprehensive employee health promotion program to their employees.
- 7.6 Increase the proportion of employees who participate in employer-sponsored health promotion activities.
- 7.10 (Developmental) Increase the proportion of tribal and local health service areas or jurisdictions that have established a community health promotion program that addresses multiple Healthy People 2010 focus areas.
- 7.11 Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.

Health Communication

- 11.4 (Developmental) Increase the proportion of health-related World Wide Web sites that disclose information that can be used to assess the quality of the site.

Maternal, Infant, and Child Health

- 16.10 Reduce low birth weight (LBW) and very low birth weight (VLBW).
- 16.12 (Developmental) Increase the proportion of mothers who achieve a recommended weight gain during their pregnancies.
- 16.19 Increase the portion of mothers who breastfeed their babies.

Physical Activity and Fitness

- 22.1 Reduce the proportion of adults who engage in no leisure-time physical activity.
- 22.2 Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.
- 22.3 Increase the proportion of adults who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion.
- 22.6 Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on five or more of the previous seven days.
- 22.7 Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion.
- 22.9 Increase the proportion of adolescents who participate in daily school physical education.
- 22.13 Increase the proportion of worksites offering employer-sponsored physical activity.

Appendix IV

California State and Local Weight-Related Surveillance Data

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and contacts for Survey/Surveillance System	Survey/Surveillance System Description

1. Behavioral Risk Factor Surveillance System (BRFSS)
Adults only

Cancer Surveillance Section
Survey Research Group

http://www.surveyresearchgroup.com/clients.asp?ID=9

Scientific Contact:
Holly Hoegh, Ph.D.
Cancer Surveillance Section
1700 Tribute Road, Suite 100
Sacramento, CA 95815-4402
(916) 779-0338
holly@ccr.ca.gov

BRFSS is an annual year-round survey used to monitor the national and state-level prevalence of personal health practices that are related to premature morbidity and mortality. The basic philosophy is to collect data on actual behaviors, rather than attitude or knowledge, which would be especially useful for planning, initiating, supporting, and evaluating health promotion and disease prevention programs. The survey has been conducted annually since 1984. Modules to assess fruit and vegetable consumption were added in 1990.

Method: Random-digit dial CATI (computer assisted telephone interview). There is a core module of questions common to all states, but each state can also add additional sets of questions about state-specific issues. Interviews are administered in English and Spanish.

Time Period: Ongoing, year-round

Population Monitored: 4,000 adults, aged 18+, in each state

Data access: Public use data sets are available through written request on agency letterhead. You will need to supply (1) your name, (2) your company or organization name, (3) your email address, (4) your telephone number and (5) your intended use/research of the survey literature. Upon receiving this information you will be issued a user I.D. and password. Weights provided with the dataset adjust for gender, age, and race/ethnicity to correct discrepancies between the sample and the California adult population.

Query System: An interactive query system is available on the national website. Prevalence data by total state population, gender, age, race, income, or education. Trend data for total state–can compare to nation or another state. http://apps.nccd.cdc.gov/brfss/

Reports/Publications: http://www.surveyresearchgroup.com/publications.asp—Points of Interest 2002, Points of Interest 2001, Points of Interest 2000, Healthy People 2000 Objectives

Geographic Unit of Analysis: National and state-level only through query system. The data set could be used to do limited county-level analysis for larger counties.

Weight-Related variables: Anthropometric measures (height, weight, calculated BMI), weight control practices, health status (selected measures), cholesterol screening practices, awareness and treatment, fruit and vegetable consumption, physical activity; in California, a food security module will be administered in 2003.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description

2. California Women's Health Survey (CWHS)
Adult women

Cancer Surveillance Section
Survey Research Group
http://www.surveyresearchgroup.com/clients.asp?ID=11
(916) 779-0338

Scientific Contact:
Marta Induni
Cancer Surveillance Section
1700 Tribute Road, Suite 100
Sacramento, CA 95815-4402
(916) 779-0338
marta@ccr.ca.gov

The CWHS is an annual population-based, year-round survey designed to gather information about health-related attitudes and behaviors and access to health care services among California women. The survey began in March 1997 and is a collaborative effort between the California Department of Health Services (CDHS), Department of Mental Health, Department of Alcohol and Drug Programs, Department of Social Services, California Medical Review Inc. (now Lumetra), and the Public Health Institute (PHI), with the CDHS Office of Women's Health (OWH) serving as the coordinating program. The CWHS was established to provide information to policymakers and health professionals about women's health, and to serve as a catalyst for innovative solutions that will impact the health of women and girls in California.

Method: Random-digit dial CATI. A core set of questions is asked annually, supplemented by questions of interest to participating programs that vary from year to year. Interviews are administered in English and Spanish.

Time Period: Ongoing, year-round

Population Monitored: 4,000 adult women aged 18+, throughout California

Data Set Access: To obtain a copy of the CWHS Survey Instrument, Technical Documentation, or Data sets contact the Survey Research Group at srg@ccr.ca.gov. Weights provided with the dataset adjust for age and race/ethnicity to correct discrepancies between the sample and the California adult population using the most recent population estimates from the California Department of Finance, i.e., Baseline 1997 Population Projection Series, 1990-1996.

Reports/Publications: Selected findings from the 1997, 1998, and 1999-2000 CWHS are available as Issues 1, 2, and 3 of Data Points on the OWH website at http://www.dhs.cahwnet.gov/director/owh/html/whs.htm

Geographic Unit of Analysis: State-level for OWH-issued Data Points results. The data set could be used to do limited county-level analysis for larger counties.

Weight/Nutrition-Related Variables: BMI (height/weight), weight control practices, body image, insurance status, insurance coverage for nutrition/weight loss, dietary quality and beliefs (fruit/vegetable), physical activity behavior and beliefs, access to health care, prenatal care, nutrition, breastfeeding, folate knowledge, hunger, food insecurity, use of food assistance programs.

Limitations: Self-reported data. Some questions are administered only once or infrequently. Not all questions are validated.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description

3. California Health Interview Survey (CHIS)
Adults, teens, and children

UCLA
Center for Health Policy Research
www.chis.ucla.edu
(866) 275-2447

Scientific Contact:
Charles DiSogra, Dr.P.H.
Director, California Health Interview Survey
UCLA Center for Health Policy Research
10911 Weyburn Ave.,
Suite 300
Los Angeles, CA 90024-2887
(310) 794.0946
cdisogra@ucla.edu

CHIS is the largest state health survey conducted in the United States. It is a collaborative project of the University of California, Los Angeles (UCLA) Center for Health Policy Research, CDHS, and PHI. CHIS is conducted biennially and was first administered in 2001. Since CHIS interviews a large sample every two years, it provides health planners, policymakers a fuller picture of health and health care needs at both the state and local level and for major race/ethnic groups. The sample is cross-sectional, independently drawn each cycle. Respondents available for follow-back studies.

Method: Random-digit dial CATI interviews are administered in English, Spanish, Mandarin Chinese, Cantonese Chinese, Vietnamese, Korean, and Khmer (Cambodian).

Time Period: Every two years, six to seven months across the year. Starting month may vary.

Population Monitored: Over 55,000 adults, 5,800 teens, and 12,592 children participated in the first CHIS survey in 2001. CHIS will provide statewide estimates for California's overall population, its major racial and ethnic groups, and a number of smaller ethnic groups. An adult proxy responds for children under 12.

Data Set Access: For public use data files—http://www.chis.ucla.edu/main/default.asp?page=puf. Contains demographic variables, but not substate identifiers (county, city, ZIP code). All detailed data, including sensitive variables and local level information, available through CDHS Center for Health Statistics or UCLA (see http://www.chis.ucla.edu/pdf/DAC_FS_092002.pdf).

Query System: The CHIS website contains the interactive system, AskCHIS. AskCHIS lets you select health topics that interest you and then quickly see the results in tables and graphs. These data can be queried for the whole state or for a single county (33 counties), county group (eight groups of the smallest counties), or regional group of counties. There is no cost, but you are required to register, obtain a password, and login.

Reports/Publications: A report on the Food Security 2001 CHIS data can be found on the CHIS website, with additional information at http://www.cfpa.net/hungerrelease.htm

Geographic Unit of Analysis: State-level data for all questions and populations. County-level data for counties with population of 100,000 or more, but sample size may result in unstable estimates for some groups.

Weight-related Variables: The adult survey provides information regarding demographics, health status, BMI, fruit/vegetable intake (2001), physical activity (2001), access to health care, public program eligibility, and food insecurity. The adolescent survey includes information on BMI; fruit, vegetable, soda, and milk consumption; and physical activity and sedentary pursuits (TV/video/computer for fun). The child survey includes BMI, the same dietary variables as for teens (but only for the time the child spent not in school/day care) and time spent on TV/video/computer games.

Limitations: Self-reported data. Varies by age group. Questions about children's dietary intake include only the period child was not at home or at school. Diet and physical activity questions not asked in 2003.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description

4. California Dietary Practices Survey (CDPS)
Adults

CDHS; Cancer Prevention and Nutrition Section
Division of Chronic Disease and Injury Control
www.dhs.ca.gov/cpns/research/index.html
(916) 449-5400

Scientific Contact:
Sara Cook, M.P.H., C.H.E.S.
Cancer Prevention and Nutrition Section
(916) 449-5390
scook1@dhs.ca.gov

The CDPS is the most comprehensive population-based dietary survey conducted in California. Developed to address dietary and physical activity monitoring of a representative sample of California adults, the CDPS has been conducted every other year since 1989. Results help track changes and provide direction in the development of health promotion campaigns and programs.

Method: Random-digit dial CATI (computer assisted telephone interview). Interviews are administered in English and Spanish.

Time Period: Mid-summer to mid-fall (about July–October) in odd-numbered years.

Population Monitored: This survey tracks the dietary and physical activity habits and patterns of Californians age 18+ and usually includes 1,000 general population respondents. In many years, a disparities-related over sample of 400-700 is included. Analysis is conducted by gender, gender by age group, race/ethnicity, education and household income after data are weighted for California for income by ethnicity by age per the 1990 U.S. Census.

Data Set Access: Public use data sets not available.

Publications/Reports: Seven major reports include trends findings, findings specific to low-income Californians, detailed findings related to fruit/vegetable consumption, attitudes, etc. The most recent research report on ten-year trends in fruit and vegetable consumption: http://www.phi.org/publications/researchreport.pdf.

For a list of other available reports and copies of the survey instruments see http://www.dhs.ca.gov/cpns/research/rea_surveys.html.

Geographic Unit of Analysis: State-level data for all questions and populations.

Weight-Related Variables: The foundation of the survey is a simplified, structured 24-hour recall identifying fruits, vegetables, and other selected high- and low-nutrient foods consumed on the day prior to the interview; daily number of servings of fruits and vegetables and other specific categories of foods; awareness of the recommended number of servings of these foods; motivations for and barriers to eating fruits, vegetables, and other healthy foods; out of home eating; minutes of physical activity; motivations for and barriers to physical activity; other knowledge, attitudes, and behaviors about physical activity; food security (beginning 2001).

Limitations: Self-reported, seasonal data. Findings are not available at the county level.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description

5. California Teen Eating, Exercise, and Nutrition Survey
(CalTEENS)

CDHS, Cancer Prevention and Nutrition Section
Division of Chronic Disease and Injury Control
www.dhs.ca.gov/cpns/research/index.html
(916) 449-5400

Scientific Contact:
Sharon Sugerman, M.S., R.D., L.D., F.A.D.A.
Cancer Prevention and Nutrition Section
(916) 449-5406
ssugerma@dhs.ca.gov

The California Teen Eating, Exercise, and Nutrition Survey is the most comprehensive diet and physical activity survey conducted among California adolescents. Although socio-economic status (SES) is not collected from the adolescents, surrogate SES measures were added to the 2002 survey.

Method: Random-digit dial CATI interviews are administered in English and Spanish.

Time Period: Spring to mid-summer (March–late June) in even-numbered years, beginning in 1998.

Population Monitored: A random sample of California teenagers, age 12–17, with a sample size of about 1,200. Analysis is conducted by gender, gender by age group (12–13, 14–15, 16–17), race/ethnicity, body weight status, physical activity status, and smoking status after data are weighted for California by age, gender, and race/ethnicity per the 1990 U.S. Census.

Data Set Access: Public use data sets not available.

Reports/Publications: *1998 California Teenage Eating, Exercise, and Nutrition Survey (CalTEENS)* Full Technical Report with Survey Instrument and Data Tables. Contact research@dhs.ca.gov for report and copies of the survey instruments.

Weight-Related Variables: The foundation of the survey is a simplified, structured 24-hour recall identifying fruits, vegetables, and other selected high- and low-nutrient foods consumed on the day prior to the interview; daily number of servings of fruits and vegetables and other specific categories of foods; awareness of the recommended number of servings of these foods; motivations for and barriers to eating fruits, vegetables, and other healthy foods; consumption of fast food; minutes of physical activity; motivations for and barriers to physical activity; participation in school and extracurricular physical activity; other knowledge, attitudes, and behaviors about physical activity; school environment; tobacco usage.

Geographic Unit of Analysis: State-level data for all questions and populations.

Limitations: Self-reported, seasonal data. Findings are not available at the county level. The African-American sample is small.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description

6. California Children's Healthy Eating and Exercise Practices Survey (CalCHEEPS)

CDHS, Cancer Prevention and Nutrition Section
Division of Chronic Disease and Injury Control
www.dhs.ca.gov/cpns/research/index.html
(916) 449-5400

Scientific Contact:
Angie Jo Keihner, M.S.
Cancer Prevention and Nutrition Section
(916) 449-5389
akeihner@dhs.ca.gov

This survey fills a gap in monitoring children's eating and activity habits in California, since there is no other in-depth statewide survey about eating and exercise practices of California's children. Because the potential population represents only 12 percent of California households, the sample is drawn from a market research pool that identifies qualified households that contain a child in the correct age range. The market research method eliminates the logistics and costs of collecting data through in-class or field-based surveys.

Method: Unlike the Cancer Prevention and Nutrition Section adult and teen telephone surveys, this survey consists of a mailed two-day food and physical activity diary completed by the child, with parental assistance. A follow-up telephone survey about attitudes, beliefs, and knowledge is conducted with the child alone to encourage free expression of ideas. This survey is implemented in the English-language only.

Time Period: Mid-spring to mid-summer (April–late June) in odd-numbered years.

Population Monitored: About 800 children age 9-11 years old, in California. Analysis is conducted by gender, race/ethnicity, body weight status, physical activity status, participation in federal school meal programs, household income, and participation in classes on physical activity and on nutrition after data are weighted for California household income, gender, and race/ethnicity per the most recent Current Population Survey of California.

Data Set Access: Public use data sets are not available.

Reports/Publications: Three 6-page reports; contact research@dhs.ca.gov for more information or to obtain a copy of the survey instruments.

- *Special Report to the American Cancer Society—Are Californians Meeting ACS Nutrition Guidelines for Cancer Prevention? Findings from Three Statewide Surveys of Children, Teens, and Adults (2001)*
- *A Special Report on Policy Implications from the 1999 California Children's Healthy Eating and Exercise Practices Survey (2001)*
- *Special Report to the American Cancer Society—1999 California Children's Eating and Exercise Practices Survey: Fruits and Vegetables, A Long Way to Go (2000)*

Weight-related Variables: Daily number of servings of fruits and vegetables and other specific categories of foods; awareness of the recommended number of servings of these foods; motivations for and barriers to eating fruits, vegetables, and other healthy foods; consumption of fast food; minutes of physical activity; motivations for and barriers to physical activity; participation in school and extracurricular physical activity; other knowledge, attitudes, and behaviors about physical activity.

Geographic Unit of Analysis: State-level data for all questions and populations.

Limitations: Self-reported, seasonal data. Findings not available at the county level. Does not include non-English-speaking children. Only about half the children who finish the diary take part in the telephone survey. The African-American sample is small.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description
7. California High School Fast Food Survey California Project LEAN (Leaders Encouraging Activity and Nutrition) Division of Chronic Disease and Injury Control http://www.californiaprojectlean.org Scientific Contact: Amanda Purcell, M.P.H. apurcell@dhs.ca.gov (916) 552-9955	Due to concern about the record levels of teen obesity, the California High School Fast Food Survey was conducted with district level food service directors in 2000 in order to examine the presence of fast foods on California high school campuses. **Method:** Mailed a self-administered survey to all (323) district-level public school food service directors with a high school in their district, and a follow-up phone interview with 50 food service directors who responded to the survey. **Time Period:** Single administration, March 1999. **Population Monitored:** N=171 responded, representing California's 345 high schools. **Data Set Access:** Public use data sets are not available. **Reports/Publications:** Survey report and additional information available on the website, http://www.californiaprojectlean.org/consumer/hsffsurvey.html. **Weight-Related Variables:** Types of fast foods being sold on California high school campuses, factors that influence fast food sales, economic and policy issues associated with these sales. **Geographic Unit of Analysis:** State-level. **Limitations:** Self-reported/administered; voluntary participation; not representative of all school districts; public schools only.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description

COUNTRY SURVEY EXAMPLE:

8. Los Angeles County Health Survey

Office of Health Assessment and Epidemiology,
Los Angeles County Department of Health Services–Public Health
www.lapublichealth.org
(213) 240-7785

Scientific Contact:
Cheryl Wold
Los Angeles County California Department of Health Services–
Los Angeles, CA 94234-7320
cwold@dhs.co.la.ca.us

The Los Angeles County Health Survey provides population-based health information about Los Angeles County adults and children. Survey topics include demographics, health behaviors, health status, access to and use of health care services, among other health-related issues. The survey was conducted in 1997 and in 1999–2000, and most recently in 2002-2003, by the Field Research Corporation for the Los Angeles County Health Department.

Method: Random-digit dial CATI; Interviews are offered in English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese.

Time Period: Administered annually during the fall and winter, when funding is available.

Population Monitored: Representative sample of over 8,000 adults and 6,000 children who live in LA County. Child data is collected from the parent about child living in household; one child is randomly selected in those households where multiple children are eligible.

Data Set Access: Available upon request.

Reports/Publications: *Meeting the Data Needs of a Local Health Department: The Los Angeles County Health Survey* http://www.ajph.org/cgi/reprint/91/12/1950.pdf; All reports and additional tables are available on the Los Angeles County California Department of Health Services website: www.lapublichealth.org/ha. Nutrition-related reports include *Hunger and Food Insecurity in Los Angeles* http://www.weingart.org/institute/research/facts/pdf/JustTheFact_Hunger_LA.pdf; Report by The Los Angeles County Task Force on Children and Youth Physical Fitness.

Weight-Related Variables: Fruit and vegetable consumption (adults), body weight (adults), physical activity and sedentary behavior (adults); breast-feeding (child), fast food consumption (child), food security (households <300% FPL), access to parks/recreational space (child), hours of TV watching (child); use of WIC services (child).

Geographic Unit of Analysis: County-level, Service Planning Areas (eight), some analysis available by health districts.

Limitations: Self-reported data, limited to households with telephones; limited data on adolescents

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description

MATERNAL AND CHILD HEALTH SURVEILLANCE MEASURES

9. Maternal and Infant Health Assessment (MIHA)
Recently pregnant women

CDHS, Maternal and Child Health Branch, Epidemiology and Evaluation Section
http://www.mch.dhs.ca.gov/epidemiology.htm
(916) 657-0324

Moreen Libet
1615 Capitol Avenue
Sacramento, CA 95814-5015
(916) 650-0393
mlibet@dhs.ca.gov

The MIHA is a collaborative project of the CDHS Maternal and Child Health Branch and the University of California, San Francisco, developed to monitor issues relating to pre- and post-natal health and to pregnancy.

Method: Self-administered surveys are mailed to women 10–14 weeks after giving birth. Birth outcomes are provided through linkage with birth certificate data. Questions may be rotated into and out of MIHA depending on data needs and emerging issues.

Time Period: Annual, first administered in 1999.

Population Monitored: A stratified random sample of about 5,000 women, over age 15, delivering live births in California during February through May; about 3,500 complete the survey. Non-responders are sent several additional mailings. After this, telephone follow-up is attempted for the remaining non-responders. There is an African-American over sample. Surveys are available in English and Spanish.

Data Set Access: Contact Moreen Libet.

Reports/Publications: The website contains a number of electronic reports relating to pre- and post-natal issues and pregnancy. See also CDHS Maternal and Child Health compiled data below.

Weight-Related Variables: Breastfeeding through about age four months; barriers to breastfeeding; risk behaviors before and during pregnancy including use of folic acid supplementation; history of low infant birth weight; maternal weight gain during pregnancy; food security-related food deficit.

Geographic Unit of Analysis: Statewide.

Limitations: Self-reported; no Asian language surveys.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description
10. CDHS Maternal and Child Health compiled data www.mch.dhs.ca.gov (916) 650-0323 Carrie Florez, BSW cflorez@dhs.ca.gov	Not a single survey, this is compiled data from a variety of sources, organized for ready reference and comparison of rankings for counties. Many data sources are used, including perinatal data, the California Birth Statistical Master file, and the California Department of Finance data. In addition to perinatal data, findings are presented for childhood injury/death and assaultive injury/death of women. **Population Monitored:** For perinatal data, pregnant and childbearing women and newborn infants in California. **Data Set Access:** Does not apply. **Reports/Publications:** *California Maternal and Child Health Data Book*–http://www.ucsf.edu/fhop/mch-data.htm. All downloadable files are .pdf files. Two files are available for each county and for Berkeley, Long Beach, and Pasadena. One file contains perinatal data; the other contains injury data. **Weight-Related Variables:** Breastfeeding at the time of hospital discharge, percent very low birth weight, percent low birth weight.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description
11. Integrated Statewide Information System (ISIS) Women and children < 5 years old, low-income CDHS; Women Infants and Children (WIC) Supplemental Nutrition Program; Primary Care and Family Health http://www.wicworks.ca.gov/default.asp (916) 928-8746 Scientific Contact: Earnestine Black, Chief Research & Evaluation Unit (916) 928-8580 eblack@dhs.ca.gov	ISIS is a transactional database intended to identify if persons who apply for WIC services are eligible for WIC. ISIS data is collected from women as part of their client assessment when they apply for WIC services and entered into an automated system. ISIS data are also collected regarding the infants and children who apply for WIC, whether or not their mother is also applying for WIC services. For example, a father could have custody of a child, and that child (or infant) could be enrolled in WIC for services. **Method:** Items are typically self-reported, except for height, weight, hemoglobin, and hematocrit, which are provided by a third party, usually a physician or clinic—sometimes the actual WIC clinic. Examples of self-reported data are: nutritional risk information (also called Risk Codes) and demographic data such as, ethnicity, age, education, and residence information. **Time Period:** Ongoing, year-round. **Population Monitored:** 1.4 million low-income women and children monthly who take part in the WIC program. **Data Set Access:** Public data set is not available. **Reports/Publications:** Contact the Chief of the Research and Evaluation Unit. **Weight-Related Variables:** Weight is collected for each individual and can be reported by category (breastfeeding women, nonbreastfeeding women, infant, child, and pregnant woman). Also available is weight information by infant feeding choice, breastfeeding (exclusively, partially, not at all), various demographics (such as age, ethnicity, residence, language spoken, country of birth, etc.), and source of medical care or social services profile (TANF, Food Stamps, etc.). **Geographic Unit of Analysis:** State level, clinic-level, zip code, and agency-level. **Limitations:** In the past, weight categories for analysis have not matched standard BMI cut points and the National Center for Health Statistics Growth Chart designations of BMI for age and gender for classification of overweight; variable protocols for measuring height/weight among physicians; consistent standards when measured by WIC nutritionists.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description

12. Pediatric Nutrition Surveillance System (PedNSS) Children and adolescents, low-income

CDHS
Children's Medical Services (CMS)
Primary Care and Family Health

Scientific Contact:
Susan Mattingly, M.S., R.D.
Nutrition Consultant
State PedNSS Coordinator
Children's Medical Services Branch
MS 8102
P.O. Box 997413
Sacramento, CA 95899-7413
(916) 322-8785
smatting1@dhs.ca.gov

The purpose of PedNSS is to monitor simple key indicators of nutritional status among low income, high risk infants, children, and adolescents who participate in publicly funded health programs. In California, data is collected from the Child Health and Disability Prevention (CHDP) Program screening appointments. Nationwide, PedNSS has been conducted continuously since 1973. In California participation has been since 1988. Data is compiled annually. The Children's Medical Services (CMS) Branch provides PedNSS data to the CHDP programs in each county on an annual basis. CMS staff provide technical assistance in interpretation of the data for local CHDP programs.

Population Monitored: Low income, high risk children, birth through 19 years of age with an emphasis on birth to five years of age. For PedNSS, most states collect data only for age birth up to five. California collects data on children up through age 19.

Method: In-person, clinical examination and laboratory tests.

Time Period: Ongoing, year-round.

Data Set Access: Public data sets are not available.

Reports/Publications: A 2001 national report is available on the Centers for Disease Control and Prevention website, http://www.cdc.gov/nccdphp/dnpa/pednss.htm. The 2002 Pediatric Nutrition Surveillance Report and data tables for the nation, state, and counties/health jurisdictions are available on the CMS Branch website (http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informationnotices/2003/chdpin03q/contents.htm). Data is presented separately for age birth to less than five and for age five to 19, as well as selected age sub-groups.

Weight-Related Variables: Low or high birth weight, anemia (low hemoglobin or low hematocrit), underweight, overweight, at risk for overweight (age two–19 only), and short stature.

Geographic Unit of Analysis: National, state, and county-level.

Limitations: Low-income children only; No national PedNSS data for children age five to 19.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description

CALIFORNIA DEPARTMENT OF EDUCATION AND OTHER SCHOOL-BASED SURVEILLANCE MEASURES

13. California Healthy Kids Survey (CHKS)
Fifth, seventh, ninth, and eleventh grade children

Healthy Kids Program Office
California Department of Education

Mr. Robin Rutherford
rrutherf@cde.ca.gov

Scientific Contact:
Greg Austin, Ph.D.
WestEd
4665 Lampson Ave.
Los Alamitos, CA 90720
(562) 598-7661, Ext. 5155
gaustin@wested.org

The CHKS is a comprehensive youth health risk behavior and resilience survey funded primarily by the California Department of Education (CDE); some cost, about $.25/pupil, is covered by the school administering the test. CHKS provides school districts with an instrument to assess an array of health indicators related to academic success and well being. It is a flexible, modular survey designed to be easily customized to meet local needs. Questions of local interest can be added. The Core module of the secondary school survey includes questions about height and weight, physical activity, diet, and asthma diagnosis and must be administered by all participants. In addition, it includes one item that assesses the reliability of answers. A Resilience and Youth Development Module assesses environmental assets in the school, community, home, and peer group, as well as individual assets. Module E, Physical Health, provides detailed information on physical activity in and out of school, body image, behaviors related to weight loss or maintenance, physical risks associated with sports and motor vehicles, and general health, including doctor visits. Starting in the 2003-04 school year, all school districts that receive funds under the federal Safe and Drug Free Schools and Communities Act and state Tobacco Use Prevention Education grants are required to administer the Core module and the school asset questions every two years. All other modules are optional. There is a fee for the addition and reporting of custom questions. The elementary school survey provides baseline data to support the implementation of comprehensive, developmentally appropriate K-12 prevention and health programs. With its other questions, it provides a comprehensive overview to health-related behavior and attitudes, and meets the requirements of the No Child Left Behind Act.

Methods: Voluntary, self-report cross-sectional survey administered in the classroom by school staff; it is anonymous and confidential. Written parental consent is required. Core must be administered by all participating districts; selected Resilience Module questions will be required of all participants beginning 2003–04. Can be adapted for longitudinal studies tracking students.

Time Period: Implemented in 1998; annual; biennial requirement starting 2003–04, but can be administered more frequently (higher fees apply); ongoing, district selects time of administration.

Population Monitored: California fifth, seventh, ninth, and eleventh graders in school districts that agreed to administer the survey, as well as all students in nontraditional (alternative) secondary school settings. The elementary instrument may also be administered to students in grades four and six. The sample size is large, with much ethnic diversity. Representative district-wide sample, selected by contractor; targets 900 students/grade; school-level surveys optional. School sample: If there are over ten schools per grade in the district, schools are randomly sampled (only 13 districts). Student sample: For districts with 900 or fewer students per grade, all students are surveyed. For larger districts, classrooms totaling 900 students are randomly selected (15 percent of districts). For the 2001–02 CHKS, the sample participating in the CHKS Core was Grade seven: 102,941, Grade nine: 82,528, Grade 11: 68,352, and nontraditional (mostly continuation): 11,777. A schedule of survey administration since 1998 by district and county is available at the survey website www.wested.org/hks.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description
13. California Healthy Kids Survey (CHKS) (cont'd)	**Data Set Access:** Aggregated county-level datasets can be obtained by the County Office of Education generally through the Safe and Drug Free Schools and/or Health Education and Prevention program for those counties that met participation criteria ($150/module for each printed report; $50 fee for basic SPSS data file. An MOU must be signed guaranteeing no survey results will ever be released that identify a school or district by name or enable such identification in any other way without district approval. An aggregated state database is not available at this time to users outside of CDE, but a comparison of statewide results is available for the required questions from the biennial California Student Survey. **Reports/Publications:** The CHKS survey instruments, background information, sample reports, administration guidelines, and other support materials, and a report on the relationship between risk factors and academic performance index scores can be found at: http://www.wested.org/hks/chkshome.htm; 2001 Youth Risk Behavioral Survey (YRBS) results of comparable weight/nutrition/physical activity questions for San Diego, San Bernardino, and San Francisco counties can be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5104a1.htm. County-level data tables and local Technical and Key Findings reports can be obtained as indicated above under "Data Set Access." **Weight-Related Variables:** Elementary school survey: body image, dieting, frequency of physical activity; middle and high school surveys: consumption of milk, soda pop, fruits/vegetables, breakfast; participation in moderate, vigorous, and strengthening physical activity; feeling of safety in one's neighborhood. Beginning with the 2002-03 middle and high school surveys, self-reported height and weight was added to the Core. Questions are based on the California Student Survey and the California Independent Tobacco Evaluation Survey, as well as the national YRBS, which has not been administered statewide since 1999. **Geographic Unit of Analysis:** The survey is conducted at the school district level, so all school districts receive findings at that level. For about 85 percent of districts, representative data are also available at the school level. County-level data are available through the County Office of Education. For spring 1998–spring 2002, the aggregated state database contains over one million student records from 75 percent of school districts, representing 92 percent of California enrollment. Representative statewide data are provided by the biennial California Student Survey, which now incorporates all the required items from the CHKS. **Limitations:** Self report. The results of this survey are not representative of California as it is only administered selectively at the discretion of individual school districts. In any given year, not all districts in a county may have conducted the survey and the findings may not be representative of the county as a whole. Data are primarily from public schools; the test is not administered by trained surveyors; the student may not feel his/her results are confidential since the survey is administered in a public setting; data are better for generating hypotheses than for answering questions.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description

14. California Student Survey (CSS)
Seventh, ninth, and eleventh grade children

Office of the Attorney General
Department of Alcohol and Drug Programs

California Department of Education
Healthy Kids Program Office

Department of Health Services
Office of AIDS

Scientific Contact:
Greg Austin, Ph.D.
WestEd
4665 Lampson Ave.
Los Alamitos, CA 90720
(562) 598-7661, Ext. 5155
gaustin@wested.org

This biennial survey, legislatively mandated since 1991, is administered by the office of the Attorney General of California and is designed to provide current and long-term information on alcohol, tobacco, and other drug use and related attitudes. For the 8th CSS, in 1999 the core CHKS questions, including physical activity, nutrition, and resilience measures, were added to provide additional state-representative data in those topic areas.

Methods: Repeated, cross-sectional, voluntary, self-report survey administered in the classroom by surveyors trained by the contractor; it is anonymous and confidential. Written parental consent is required.

Time Period: Conducted biennially since 1985, fall-winter odd years.

Population Monitored: California youth in grades seven, nine, and eleven. For 2001-02, the total sample participating in the CSS was 8,238; Sample: representative statewide sample, selected by contractor; target 2,500 students/grade; School sample: random sample of about 125 public and private schools statewide—high schools and paired feeder middle schools; Student sample: up to three randomly selected classrooms in required courses per grade/school.

Data Set Access: Contact Greg Austin, Ph.D.

Reports/Publications: Downloadable 2001-02 CSS survey instruments that include the CHKS comparable core nutrition and physical activity questions can be found at http://www.wested.org/hd/css/. Data tables for the 2001-02 CHKS comparison variables are available on the website, http://www.wested.org/hks/css2001.pdf.

Weight-Related Variables: Consumption of: milk, soda, fruits/vegetables, breakfast; participation in moderate, vigorous, and strengthening physical activity; feeling of safety in one's neighborhood; includes all items in CHKS Core Module A., middle/high school. Comparable to YRBS and national Monitoring the Future Survey. Height and weight questions were added in 2003.

Geographic Unit of Analysis: Aggregated state-level findings.

Limitations: Self report; data is primarily from public schools. The student may not feel his/her results are confidential, since the survey is administered in a public setting.

Nutrition, Weight Status, Physical Activity, and Sedentary Behavior

Name and Contacts for Survey/Surveillance System	Survey/Surveillance System Description

15. California Physical Fitness Test *(FITNESSGRAM)*
Fifth, seventh, and ninth grade students

http://www.cde.ca.gov/statetests/pe/pe.html

California Department of Education
www.cde.ca.gov

Debbie Vigil
Standards and Assessment Division
California Department of Education
1430 N Street, Suite 5408
Sacramento, CA 94244-2720
(916) 319-0341
dvigil@cde.ca.gov

The California Physical Fitness Test is a statewide student physical fitness test directed by AB 265 in 1995 to be administered at least once every two years. Beginning in spring 2001, CDE determined to collect and report data every year. The physical fitness test is a required element of the School Accountability Report Card. The State Board of Education designated the *FITNESSGRAM* as the required physical performance test to be administered to California students.

Method: *FITNESSGRAM* is not a survey instrument; it is a set of measured physical fitness tests. Local districts administer the *FITNESSGRAM* according to the test administration directions included in the *Fitnessgram* test administration manual and report the results of the test to CDE.

Time Period: Annually during the months of February, March, April, or May.

Population Monitored: California fifth, seventh, and ninth graders are tested. Although the test is mandated, the extent of testing has been affected by logistical and fiscal issues. Approximately 46 percent and 70 percent of California students were tested in 1997 and 1999, respectively. Approximately 92 percent of school districts submitted data in 2002, an increase of two percent from 2001.

Data Sets Available: Contact Debbie Vigil.

Pulications/Reports: State, county, district, and school level results are available on the website for 1998–99, 2000–01, and 2001–02 school years at http://data1.cde.ca.gov/dataquest/ by choosing "Physical Fitness Results" as the subject and the appropriate level. Subgroup data is also available by gender and race-ethnicity. Background and test administration information is available at http://www.cde.ca.gov/statetests/pe/pe.html.

(A state assembly-district level report on overweight and lack of aerobic capacity "unfitness" can be found at http://www.publichealthadvocacy.org/policy_briefs/study_documents/Policy_Brief1.pdf; with additional information, district-specific fact sheets, and an interactive map at http://www.publichealthadvocacy.org/policy_briefs/overweight_and_unfit.html; State senate district level planned. NOTE: These district-level reports were done by the California Center for Public Health Advocacy and not CDE.)

Weight-Related Variables: Six fitness tests: aerobic capacity, body composition (usually by BMI, but could be by skin fold), abdominal strength, trunk strength, upper body strength, and flexibility.

Geographic Unit of Analysis: State, county, district, and school-level data available are on the CDE website. state assembly district level (and state senate district level will be available soon) available via the California Center for Public Health Advocacy. (NOTE: CDE will not be collecting this data.)

Limitations: Standardized training for test administrators is lacking, which impacts inter- and intra-tester reliability and validity. Knowledge, attitudes, and beliefs are not examined.

Summary of Types of Available California State and Local Weight-Related Surveillance Data

Name of Survey/ Surveillance System	Fruit and Vegetable (FV)	Body Weight/ BMI	Physical Activity	Sedentary Behavior	Food Insecurity	Other
Behavioral Risk Factor Surveillance System (BRFSS) http://www.surveyresearchgroup.com/clients.asp?ID=9 Adults 18+ Self reported	Non-quantified six questions, usual FV intake Knowledge and belief questions 1990–91, 1994, 1996, 1998, 2001-03	BMI 1984-2003	Usual exercise in a week–moderate and vigorous(seven questions) 1985–89, 1991–92, 1994,1996, 1998, 2001–03	Any physical activity in the last 30 days 1984–92, 1995–96, 1998, 2000–2003	USDA six-question brief food security module beginning in 2003 (California)	Milk consumption 1994
California Women's Health Survey (CWHS) http://www.surveyresearchgroup.com/clients.asp?ID=11 Adult Women 18+ Self reported	Semi-quantified single question, usual servings FV intake Single question FV belief 2000–03	Belief question about healthy weight Weight loss and dieting questions (# varies) BMI 1997-2003	Past 30 days any physical activity Usual exercise in a week–moderate and vigorous 1998–99 2001–03 Also belief in 2001/02 Stair climbing–98	Time spent sitting (one question) 1998, 2001	USDA six-question brief food security module and multiple questions about use of food assistance programs 1997–98 2000–03	Breastfeeding 1997–2001 Milk consumption
California Health Interview Survey (CHIS) Adult www.chis.ucla.edu Adults 18+ Self reported 2001, 2003	Non-quantified, usual FV intake, frequency, past month, eight questions (only 2001)	BMI	Activity/exercise for transportation Over the past 30 days, frequency and duration of moderate and vigorous exercise (only 2001) Over the past 30 days, strength exercise questions (only 2001)	Non free time activity level (only 2001)	USDA six-question brief food security module, only asked of adults below 200 percent of poverty	

Summary of Types of Available California State and Local Weight-Related Surveillance Data

Name of Survey/ Surveillance System	Fruit and Vegetable (FV)	Body Weight/ BMI	Physical Activity	Sedentary Behavior	Food Insecurity	Other
California Health Interview Survey (CHIS) Adolescent www.chis.ucla.edu Adolescents 12–17 Self reported 2001, 2003	Non-quantified four questions, FV servings yesterday (only two questions in 2003)	BMI	Past seven days frequency and duration of moderate and vigorous exercise Past seven days frequency and duration of strength exercises Sports team participation (only 2001)	On a typical weekday, number of hours watching television and number of hours using computer **not** for school work, two questions (only 2001) On the weekend number of hours watching television and using computer **not** for school work, two questions (only 2001)		Questions on glasses of milk (one question) and soda (one question), servings yesterday
California Health Interview Survey (CHIS) Child www.chis.ucla.edu Children Under 12 Parent reported 2001, 2003	Non-quantified four questions, FV servings yesterday (only two questions in 2003) Only when child is not in school or day care	BMI		On a typical weekday, number of hours watching television and number of hours using computer **not** for school work (only 2001) On the weekend number of hours watching television and using computer **not** for school work (only 2001)		Glasses of milk yesterday Glasses of soda yesterday

Summary of Types of Available California State and Local Weight-Related Surveillance Data

Name of Survey/ Surveillance System	Fruit and Vegetable (FV)	Body Weight/ BMI	Physical Activity	Sedentary Behavior	Food Insecurity	Other
California Dietary Practices Survey (CDPS) www.dhs.ca.gov/cpns/research/index.html Adults 18+ Self reported 1989–2003 biennial	Semi quantified, limited structured 24 hour recall (FV intake yesterday) Many questions on knowledge, attitude and belief	BMI, beginning in 1999 Weight loss and dieting questions	Past week frequency and duration of moderate and vigorous physical activity Many knowledge, attitude, and belief questions	Time spent watching TV yesterday (2003)	USDA six-question brief food security module, beginning in 2001	Household income Other foods; out of home eating Diet-disease relationship knowledge (will not be asked in 2003)
California Teen Eating, Exercise, and Nutrition Survey (CalTEENS) www.dhs.ca.gov/cpns/research/index.html Adolescents 12–17 Self reported 1998, 2000, 2002	Semi quantified, limited structured 24 hour recall (FV intake yesterday) Many questions on knowledge, attitude and belief	BMI Body image and dieting questions	Past 30 days frequency and duration of moderate and vigorous physical activity Many knowledge, attitude, and beliefs questions	Frequency and duration of time spent watching television and using the computer **not** for school work		Socio-Economic surrogates Participation in school meals School Environment Other foods; fast food; meals
California Children's Healthy Eating and Exercise Practices Survey (CalCHEEPS) www.dhs.ca.gov/cpns/research/index.html Children 9–11 Parent-assisted, self reported (diary); self reported (phone interview) 1999, 2001, 2003	Two-day diary and telephone interview Many questions son knowledge, attitude, and beliefs	BMI from parent	Two-day diary: type of activity, length of time, and intensity Questions on knowledge, attitude, and beliefs Days per week and length of time spent in physical education classes at school	Two-day diary: length of time spent watching TV/videos or playing computer/video games for fun. Preference: time spent watching television or being physically active Environment: parents limiting time spent on sedentary activities (2001 and 2003)	Household food stamp usage	Family income Participation in school meals Other foods; fast food; meals

Summary of Types of Available California State and Local Weight-Related Surveillance Data

Name of Survey/ Surveillance System	Fruit and Vegetable (FV)	Body Weight/ BMI	Physical Activity	Sedentary Behavior	Food Insecurity	Other
California High School Fast Food Survey http://www.calfornia projectlean.org High school students 2000						Fast Food availability on high school campuses
Los Angeles County Health Survey www.lapublichealth.org Adults 18+ Self reported Adult Questionnaire 2002–03	Non-quantified, single question, FV servings yesterday Single question FV beliefs	BMI	In a usual week, frequency and duration of moderate and vigorous physical activity		Food insecurity with and without hunger; Participation in supplemental food program and food stamps	
Los Angeles County Health Survey www.lapublchealth.org Children 0–17 Parent reported Parent Questionaire for Child 2002–03			Number of days in a typical week spent participating in organized sports Access to parks/ recreational space	Number of hours spent watching television on a typical day	Participation in WIC (during pregnancy and after child was born)	Breastfeeding Breakfast yesterday Fast food yesterday
Pediatric Nutrition Surveillance System (PedNSS) smatting@dhs.ca.gov Measured 1988-2002		Overweight (>95th percentile) At risk for overweight (85^{th}–95^{th} percentile)				Underweight Short stature Anemia

Summary of Types of Available California State and Local Weight-Related Surveillance Data

Name of Survey/ Surveillance System	Fruit and Vegetable (FV)	Body Weight/ BMI	Physical Activity	Sedentary Behavior	Food Insecurity	Other
California Healthy Kids Survey (CHKS) http://www.wested.org/hks/css2001.pdf Grades 5, 7, 9, & 11 Self reported Annual 1999–2003 **California Student Survey (CSS)** Grades 7, 9, & 11 Self reported Annual 1989–1999 Surveys used the same set of questions (except for the sedentary behavior questions, which are in the CHKS module but not included in the CSS module.)	Middle school: non-quantified four questions, 24 hour recall (yesterday) High school: non-quantified four questions, 24 hour recall (yesterday)	Elementary: two questions about body image, one question on dieting Middle: height and weight; 3 questions about body image/dieting High school: height and weight; three questions about body image/dieting	Elementary number of days you exercise per week Middle: past seven days vigorous, moderate, and strengthening exercises, and participation in organized sports High school: past seven days vigorous and strengthening exercises, and participation in organized sports	Elementary: Number of hours spent watching television or played video games yesterday Middle: On an average school day, number of hours spent watching television or playing video games (CHKS only) High school: On an average school day, number of hours spent watching television or playing video games (CHKS only)		Elementary: breakfast today and milk yesterday Middle: any breakfast today and milk yesterday High school: breakfast today and milk yesterday CSS includes alcohol and drug use questions
Youth Risk Behavior Survey (YRBS) http://www.cdc.gov/nccdphp/dash/yrbs/index.htm Grades 9–12 Self reported 1991–2003 Conducted in; San Diego, San Francisco, Los Angeles (no longer administered in California; succeeded by CHKS and CSS)	Non-quantified six questions, intake over the past seven days	BMI Weight loss and diet questions	Frequency of moderate (30+ minutes) and/or vigorous (20+ minutes) exercise in the past seven days Strength exercises in the last seven days Participation in PE classes and organized sports	Watched less than two hours of television		Glasses of milk over the past seven days

Summary of Types of Available California State and Local Weight-Related Surveillance Data

Name of Survey/ Surveillance System	Fruit and Vegetable (FV)	Body Weight/ BMI	Physical Activity	Sedentary Behavior	Food Insecurity	Other
California Physical Fitness Test, FitnessGram http://www.cde.ca.gov/statetests/pe/pe.html Grades five, seven, and nine Measured 1998–99, 2000–01, 2001–02		Body composition as measured by BMI or skin fold–usually BMI	Five Performance Tests: • Aerobic Capacity • Trunk extension • Abdominal Strength • Upper Body Strength • Overall Flexibility			
Maternal and Infant Health Assessment Women aged 15+ who recently gave birth Self-reported		Weight before pregnancy; weight gain during pregnancy; height			Multiple questions about financially caused restrictions on food amount and sufficiency, and nutritional balance	Breastfeeding, folic acid, history of low infant birth weight, supplementation

Appendix V

Useful Websites

General obesity, Nutrition and Physical Activity Resources

Adolescent Family Life Program (AFLP) www.mch.dhs.ca.gov/programs/aflp

American Dietetic Association www.eatright.org

American Heart Association www.americanheart.org

American Obesity Association www.obesity.org

California Center for Physical Activity www.caphysicalactivity.com

California Center for Public Health Advocacy www.publichealthadvocacy.org

California Department of Education www.afterschoolpa.com

California Diabetes Prevention and Control Program www.caldiabetes.org

California Health Interview Survey www.chis.ucla.edu

California Obesity Prevention Initiative www.dhs.ca.gov/obesityprevention

California Project LEAN (Leaders Encouraging Activity and Nutrition) www.CaliforniaProjectLean.org

California Walk to School Headquarters www.cawalktoschool.com

California Nutrition Network and the California 5 A Day Program www.ca5aday.com

Centers for Disease Control and Prevention www.cdc.gov

Center for Weight and Health, UC Berkeley www.cnr.berkeley.edu/cwh

Healthfinder *(An award-winning federal website for consumers, developed by the U.S. Department of Health and Human Services together with other federal agencies.)* www.healthfinder.gov

Institute of Medicine www.iom.edu/

Healthy People 2010 www.healthypeople.gov

Continued on next page

National Heart, Lung, and Blood Institute of the National Institutes of Health www.nhlbi.nih.gov

North American Association for the Study of Obesity www.naaso.org

Nutrition Gov www.nutrition.gov

President's Council on Physical Fitness and Sports www.fitness.gov

Prevention Institute www.preventioninstitute.org

School Health Connections www.dhs.ca.gov/schoolhealth

Shape Up America www.shapeup.org

Spectrum of Prevention and the Strategic Alliance for Healthy Food and Physical Activity Environments www.preventioninstitute.org

Strategic Alliance www.eatbettermovemore.org

"The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity" www.surgeongeneral.gov

United States Department of Agriculture Food and Nutrition Information Center www.nal.usda.gov/fnic

Smart Growth Resources

www.smartgrowthamerica.com

www.lgc.org

www.leadershipforactiveliving.org

www.planning.org

www.healthytransportation.net

www.bikewalk.org

Appendix VI

Acronyms

BRFSS Behavior Risk Factor Surveillance System

CalCHEEPS California Children's Healthy Eating and Exercise Practices Survey

CalTEENS California Teen Eating, Exercise, and Nutrition Survey

CDC Centers for Disease Control and Prevention

CDE California Department of Education

CDHS California Department of Health Services

CHIS California Health Interview Survey

CFPA California Food Policy Advocates

CMS Children's Medical Services Branch

COPI California Obesity Prevention Initiative

MCH Maternal and Child Health Branch

PedNSS Pediatric Nutrition Surveillance System

PHI Public Health Institute

SOFIT System for Observing Fitness Instruction Time

SOPLAY System for Observing Play and Leisure Activity in Youth

SPARK Sports, Play and Active Recreation for Kids!

WIC Women, Infants, and Children Supplemental Nutrition Branch

California Obesity Prevention Initiative
California Department of Health Services

P.O. Box 997413
MS 7211
Sacramento, CA
95899-7413

www.dhs.ca.gov/obesityprevention

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2006